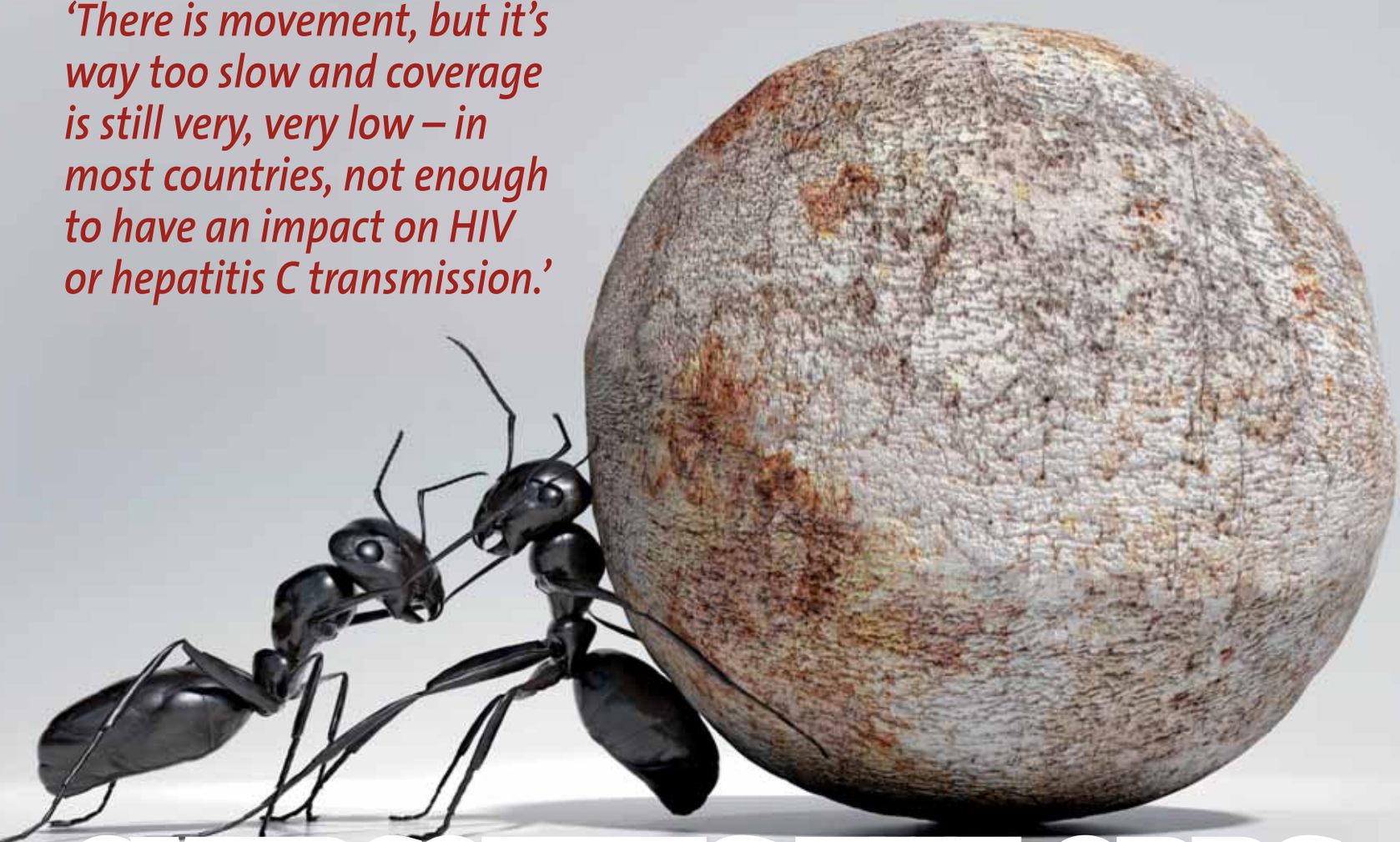
DDN
Drink and Drugs News

10 May 2010
www.drinkanddrugsnews.com

Special issue
DDN reports from IHRA's 21st international harm reduction conference.

Coming home: IHRA return to Liverpool for their 21st international conference

'There is movement, but it's way too slow and coverage is still very, very low – in most countries, not enough to have an impact on HIV or hepatitis C transmission.'



OVERCOMING THE ODDS

HARM REDUCTION ACTIVISTS FROM AROUND THE WORLD HAVE THEIR SAY

Greater Manchester West NHS
Mental Health NHS Foundation Trust

Alcohol & Drug Directorate Training Opportunities

Greater Manchester West Mental Health NHS Foundation Trust currently delivers community substance misuse services across Manchester, Bolton, Salford, Wigan & Leigh, Blackburn with Darwen, and in-patient services to Greater Manchester, Lancashire and Cumbria.

"We have been very pleased with the organisation & the training they have delivered. We would recommend them highly'
Hertfordshire Joint Commissioning Team 2010

The Trust holds the largest collection of research, books and journals in the UK in the form of the Ian Smith Drug Reference Library, and supports the Alcohol & Drug Directorate to employ its own dedicated workforce development and training team whose role is to develop and deliver learning and development activities to meet the needs of the substance misuse workforce. The following training will be available to external agencies in 2010/11:

- **Level 2 Award in the Management of Substance Misuse**
- **Level 2/3 Award in Working with Young People & Substance Misuse**
- **Level 3 Qualification In Tackling Substance Misuse: Practitioner Route**
- **Level 3 Specialist Unit - Management of Individuals within Substance Misuse Services**
- **Level 3 Specialist Unit – Working with Stimulant Users**
- **Level 3 Specialist Unit – Alcohol**
- **Level 3 Specialist Unit – Dual Diagnosis**
- **Motivational Interviewing Skills**
- **ITEP**
- **Facilitating Group Work**
- **Hepatitis C Dry Blood Spot Testing**
- **Hepatitis C & HIV Dry Blood Spot Testing**
- **Train The Trainers**
- **Drug Awareness & Customer Care**

If your service is interested in any of the above, or indeed other bespoke training, please contact the Workforce Development Manager, Claire Watson on 0161 772 3539 or claire.watson@gmw.nhs.uk

a+dd
[alcohol+drugs]directorate

DDN
Drink and Drugs News

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Editorial – Claire Brown

Learning curve

Lessons from global harm reduction

After a turbulent few weeks the election is finally over, with a hung parliament a certainty as we go to press. What will happen next in terms of configuring government is still anybody's guess – and has been, during the hours of tv coverage through the night. All we know is that a great deal of negotiation must take place before anything approaching a serious administration can take shape and start to make decisions that will affect us.

This issue of DDN is going to new MPs as they take up their places in the new parliament. If they get as far as reading it, they may be surprised at the contents. What, after all, does the term 'harm reduction' mean to anyone outside the substance misuse field, other than harm reduction to the public by protecting them from drug users? They may be surprised to consider such matters in terms of public health – and of life and death to people in the grip of addiction. Such matters haven't exactly featured prominently in any party's manifesto, so we hope the magazine might offer new insight into complicated lives and inspire them to take an interest.

Likewise, we hope the issue will be informative to all our readers, not just those with an obvious harm reduction remit. The IHRA conference is an opportunity to learn from experience elsewhere, informing our responses to international drug policy and its many extremes, while giving an opportunity to reassess priorities back home.

During a debate on our treatment system in the UK, Nick Barton of Action on Addiction made the point that whatever we are passionate about in this field, we should all have the shared goal of maximising wellbeing and quality of life. Polarisation would not end 'until each party looks at its own deficiencies instead of pointing the finger excitedly at the failings of the other', he said. He might equally have been talking to the political leaders – but it's a strong and dignified message for this field as we wait for the new political landscape to take shape.

This issue

FEATURES

REGULARS

News in Brief

39th Scots anthrax case

The number of confirmed cases of anthrax among injecting drug users in Scotland now stands at 39, according to Health Protection Scotland. There have been 12 deaths in Scotland (*DDN*, 26 April, page 5) as well as cases in England and Germany. Sixteen of the confirmed Scottish cases have been in the Greater Glasgow and Clyde NHS Board region, which is also the location for seven of the deaths.

Harm reduction explained

The International Harm Reduction Association (IHRA) has launched its *What is harm reduction?* briefing in 11 different languages, with more translations coming soon. *Available free at www.ihra.net Our full round up of IHRA's 21st international conference begins on page 8.*

CATS in the bag

The Centre for Addiction Treatment Studies (CATS) is holding its first alumni reunion on July 10 in Warminster, Wiltshire. The event begins at 11.00am and will mark 22 years of delivering the CATS' addictions counselling course, with co-founder of the Recovery Academy, Professor David Best, as guest speaker alongside centre director Tim Leighton. *For more information contact Patsy Ford on 01985 843783 or patsy.ford@actiononaddiction.org.uk*

Naloxone news

A new website providing a guide to all aspects of take-home naloxone has been launched by a group of independent academics and healthcare professionals. *www.take-homenaloxone.com*

Homeless action

Charity St Mungo's 2010 action week will focus on the problems homeless people can face when trying to find work. *Just the job* runs from 20-27 June and aims to raise awareness of the issues among policy makers and the public. 'Most of our residents want to work but a combination of low levels of skills and poor health means that it takes time,' said chief executive Charles Fraser. *www.mungos.org*

Consortium kicks off

The Scottish Drugs Recovery Consortium (SDRC) will hold its official launch on 1 June in Glasgow, with speakers including community safety minister Fergus Ewing MSP and SDRC chair David Best. For more information call 0141 226 1662 or email linda.swift@sdrconsortium.org. *Membership packs available to download at www.sdconsortium.org*

Scots prioritise brief interventions

Scottish NHS areas are to prioritise alcohol brief interventions as a condition of £36m funding to be shared among the country's 14 health boards.

Services in each area will be determined by local alcohol and drug partnerships 'in line with local needs', says the government, but 'all areas will prioritise brief interventions which are designed to help people reflect on and address their drinking before it causes lasting health damage'.

'Brief interventions are a key part of our strategy and they're not only clinically effective but cost effective,' said health secretary Nicola Sturgeon. 'By intervening early we can maximise resources and – more importantly – save lives. The cost of excessive drinking is too high – both in financial and health terms – which is why it's so important that we invest this money now in a healthy future for Scotland.'

Brief interventions were introduced in Scotland in 2008 as part of alcohol screening programmes. However, some of the funding will also go towards prevention, treatment and support services, the government states.

Meanwhile, claims that minimum pricing for alcohol is unfair because it would only affect low-income families has been questioned by new research from Aberdeen University. All income groups buy cheap alcohol, says *Purchasing patterns for low price alcohol: evidence from the expenditure and food survey,* with people from middle income and higher income groups just as likely to buy off-sales alcohol priced below 40p per unit as those from low income groups. The survey also found that low income households are less likely to buy off-sales alcohol overall, with one in three households buying alcohol in shops compared to two out of three of the highest income group.

'This new research indicates that concerns that low-income households will be the only ones targeted by minimum pricing may be unfounded as cheap alcohol is bought by all households,' said chair of Scottish Health Action on Alcohol Problems (SHAAP) Dr Bruce Ritson. 'In fact, as the people on the lowest incomes are less likely to buy any off-sales alcohol, they will be less affected by minimum pricing overall. Rather than being targeted at poorer households, minimum pricing will have a selective effect on the heaviest drinkers whom we know consume almost two-thirds of the low-cost alcohol. We hope this new evidence will allay some of the concerns that have been expressed and will encourage politicians in all parties to support minimum pricing.'

Report available at www.shaap.org.uk

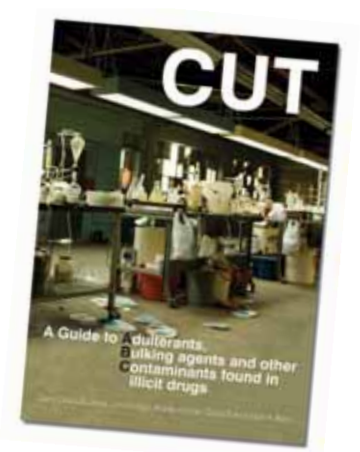
Users overestimate drug adulteration

Less adulteration of illicit drugs 'than is anecdotally perceived' by drug users actually takes place, according to a new study by the Centre for Public Health at Liverpool John Moores University.

Stories of drugs cut with brick dust, cleaning products and ground glass are 'often inaccurate', says *Cut: a guide to adulterants, bulking agents and other contaminants found in illicit drugs*. Although adulterants are 'routinely' found, these are likely to be benign, it states.

The report studied a range of drugs including heroin, cocaine, crack, amphetamine, ecstasy, cannabis and ketamine, and found that drugs were more likely to be adulterated with sugars or substances that would 'enhance or mimic the effects' of the drug, such as procaine in cocaine. Other substances found included those designed to facilitate the administration of the drug, such as caffeine in heroin and cocaine to facilitate smoking. 'By-products, bacteria or other biological agents can also adulterate illicit drugs due to poor or unsterile manufacturing and production techniques, substandard packaging and inappropriate storage,' it says.

The report wants to see research into the usefulness of media warnings about adulteration of illegal drugs, as police statements regarding 'dirty' drugs are regularly made through the media. 'There is very little evidence about their usefulness in accurately informing drug users about the health consequences of adulteration,' says the document. 'Media reports can potentially perpetuate scare mongering and reinforce myths regarding illicit drug adulteration.'



The report also calls for improved surveillance of illicit drug adulteration to address public health concerns, as well as measures to make drug users aware of the potential health effects, and it wants to see hospital emergency staff appropriately trained and equipped to respond to adulteration-related issues. 'A set of quality assured, robust and rehearsed interventions and information dissemination strategies would enhance public health and the quality and effectiveness of responses to illicit drug adulteration incidents,' the report concludes.

Report available at www.cph.org.uk

Prohibition and illegal profit 'destabilising entire countries'

Drug prohibition is responsible for violence, murder and gun crime, and illegal drug profits are destabilising whole countries, according to a new report from the International Centre for Science in Drug Policy (ICSDP).

Launched at the International Harm Reduction's (IHRA) annual conference, the report is the result of a systematic review of all available English language scientific literature on the impact of drug law enforcement on drug markets from the last 20 years.

Eighty-seven per cent of the studies looked at for *Effect of drug law enforcement on drug-related violence: evidence from a systematic review* concluded that law enforcement measures were linked to increased levels of violence. Prohibition has created a global illegal drug market worth $320bn, it says, with much of the violence the result of power vacuums created when key figures are arrested or removed.

Drug profits have effectively destabilised entire countries, says the report, including Mexico, Columbia and Afghanistan and 'contributed to serious instability' in the West African region. As prohibition has not achieved its 'stated goal of reducing drug supply, alternative models for drug control may need to be considered if drug-related violence is to be meaningfully reduced,' the report concludes.

'Among all the harms related to drug use, it now seems that the very measures most countries use to reduce drug use are actually causing harms to drug users and to the community,' said IHRA's executive director Gerry Stimson. 'Law enforcement is the biggest single expenditure on drugs, yet has rarely been evaluated. This work indicates an urgent need to shift resources from counter-productive law enforcement to a health based public health approach.'

'From a scientific perspective, the widespread drug violence in places like Mexico and the US, as well as the gun violence we are increasingly seeing on city streets in other countries appears to be directly linked to drug prohibition,' said the report's co-author Dr Evan Wood. 'Prohibition drives up the value of banned substances astronomically, creating lucrative markets exploited by local criminals and worldwide networks of organised crime. Unfortunately, the evidence suggests that any disruption of these markets through drug enforcement seems to have the perverse effect of creating more financial opportunities for organised crime groups, and gun violence often ensues.'

Report available at www.icsdp.org. Our full round up of this year's IHRA conference starts on page 8

US Project Prevention not welcome here

The American organisation Project Prevention's widely reported plans to set up in the UK have been strongly criticised by drugs agencies. The organisation, which states its number one objective as reducing 'the number of substance exposed births to zero' offers drug users an incentive payment to undergo sterilisation.

Women with drug or alcohol dependencies are offered cash incentives 'to use long-term or permanent birth control' which, says Project Prevention, is intended to 'reduce the burden of this social problem on taxpayers, trim down social worker caseloads, and alleviate from our clients the burden of having children that will potentially be taken away'. 'Unlike incarceration', it adds, this is 'extremely cost effective and does not punish the participants'. The group claims to have links with drug treatment programmes, social services departments and hospitals throughout the US.

Addaction states that 'there is no place for Project Prevention in the UK because their practices are morally reprehensible and irrelevant' while Release accuses the organisation of practising eugenics. 'While there may be real problems associated with bringing up children while dependent on illegal drugs, there are other, less drastic and potentially damaging ways of alleviating them,' says the charity. 'Contraceptive advice can be offered as part of drug treatment, and psychosocial support services may offer stability to drug dependent women. No information is provided on the group's website about the medical practicalities of the sterilisation process and Release is concerned about the medical ethics involved. The issue of informed consent also looms large; one wonders how "informed" this consent really is.'

Largest ever number of new drugs reported

A record number of new drugs were officially reported to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) during 2009, according to the *EMCDDA-Europol 2009 annual report.*

Twenty-four new psychoactive substances were officially notified via the EU early warning system on new psychoactive substances last year, says the report – the largest number ever and double the number reported the previous year. All of the new substances were synthetic, including nine synthetic cannabinoids – from four distinct chemical groups – and four synthetic cathinones. Although no new piperazines or psychoactive plants were reported, the report says growing numbers of ecstasy tablets contain the piperazine mCPP – a substance previously covered in EMCDDA reports – while the availability of MDMA appears to be in decline.

The 'appearance of a large number of new unregulated synthetic compounds' for sale on the internet represents a growing challenge, says the document. Regarding mephedrone – recently banned in the UK (*DDN*, 26 April, page 4) – the report states 'it is important to consider the threat that this may pose by creating momentum for an undesirable transition, from a mostly online 'legal-highs' market, originally driven by individual entrepreneurship, to one that involves organised crime.'

News in Brief

Time to talk

Heroin prescribing was debated at the Royal College of Nursing's (RCN) recent national congress. 'Heroin addiction is a very real and very serious health concern which has widespread social and economic impact across communities,' said chair of the RCN's Cambridgeshire branch, Carol Evans. 'It is vital that as nurses, carers and clinicians we recognise that one approach does not necessarily work for all and as such we have a duty to consider alternatives and more imaginative options.' RCN general secretary Dr Peter Carter's comments supporting the idea afterwards led to protests in sections of the press.

Route and branch

A report on how cocaine is produced and trafficked into the EU has been published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It aims to 'provide a better understanding of the actors involved, the routes taken, and the scale of the problem in Europe,' says the EMCDDA. The document highlights the use of 'secondary extraction' laboratories in Europe where cocaine smuggled in as part of other materials, such as plastic or clothing, is then extracted. *Cocaine: a European Union perspective in the global context available at www.emcdda.europa.eu/*

Vital signs

The LDPF has produced an updated version of its *Vital information pack*, with facts about drugs – including those recently made illegal – drink and keeping safe when out. For copies email ldpf@cityoflondon.gov.uk

Drug crime down

Drug offences recorded by the police fell by four per cent in the year ending December 2009 compared with the previous year, according to the Home Office bulletin *Crime in England and Wales: quarterly update to December 2009*. The statistics are 'heavily influenced by policing priorities, and may reflect changes in the policing of drug crime more than real changes in its incidence' it says. *rds.homeoffice.gov.uk*

Diazepam danger

Drug workers in Buckinghamshire have received reports from service users in High Wycombe about a white powder marketed as diazepam that can lead to blackouts and hospitalisation when used. Anyone concerned should call 023 8088 1400 or 023 8071 7171.

STAYING THE COURSE

Writing just before the election, **Paul Hayes** says the NTA is rolling up its sleeves to work with a new government on getting more people drug free

NOW THE DUST HAS SETTLED on the election campaign, and attention shifts to forming a new government, how is the drug treatment field placed to weather the challenges ahead?

Writing before we know who are the winners and losers, I believe that whatever the outcome, those who work in the treatment sector can hold their heads high. Like the rest of the public services, we face financial uncertainty, but we do so in the knowledge that our work is valued.

Drugs did not figure as a major campaign issue, and none of the manifestos or leadership pledges promised a significant shift in the direction of travel with which we are all familiar – towards getting more dependent users drug-free, while continuing to reduce crime.

However, arguably the most significant recent development for the drugs field as a whole came before the campaign kicked off, although it was quickly obscured by the politics of the moment.

Just before Easter the National Audit Office (NAO) published the findings of a searching two-year investigation into tackling problem drug use. The media gleefully seized on the report (and its subsequent endorsement by the Public Accounts Committee of the House of Commons) (PAC) to criticise the Home Office for failing to demonstrate value for money from the £1.2bn drugs budget.

Behind the headlines, however, the drug treatment field deserves to know that the NAO actually found it was doing a damn good job. The auditors accepted that treatment, which accounts for the bulk of the overall drugs spend, does deliver value for money. 'There has been good progress in a number of activities, including an increasing number of problem drug users in drug treatment; and an increasing percentage leaving treatment free from dependency,' the NAO said.

'The Drug Treatment Outcomes Research Study has estimated the benefit cost ratio for drug treatment is 2.5 to 1. The most significant and costly objectives of the Drug Strategy are supported by robust evidence.'

This means that every pound spent on treatment generates £2.50 worth of benefit to society, mostly by cutting crime. In other words, the £800m treatment budget alone delivers £2bn worth of benefit, more than the overall cost of the expenditure incurred by the whole drug strategy.

At the same time, the NAO found that the increased investment is being used more efficiently. The cost of funding for every adult in effective treatment had fallen by almost a fifth in real terms over the last five years to £3,000, for example.

Fewer problem drug users dropped out of treatment. The NAO noted: 'An increasing number of problem drug users leave treatment free from dependency on heroin or crack cocaine or the illegal drugs for which they sought treatment, but with evidence of other illegal drug use.'

The lead investigator and author of the report subsequently told a Westminster conference that the return on investment for drug treatment was among the best they had ever found in scrutinising the public sector.

These are impressive achievements, and at a time when all politicians are looking for scope to make savings, eliminate waste and cut unnecessary bureaucracy, it is heartening that independent and official auditors gave such a vote of confidence in drug treatment commissioners and practitioners.

Nevertheless the NTA is not complacent about the challenges ahead. The NAO told us specifically to do more to improve performance in those local services which were weak on successful completions. It told government generally that actions to help drug-users re-establish their lives have had limited results, particularly in securing houses and jobs.

The PAC also suggested residential rehabilitation may be effective for those who have failed to 'go clean' in other forms of treatment, and said all users in treatment required motivation to stay off drugs when back in their local communities.

We acknowledge that, having first concentrated on getting people into treatment, and subsequently retaining them long enough to benefit from treatment, the sector now needs to focus increasingly on getting people out successfully, as quickly and safely as possible.

That's why the NTA is revising the framework that governs the commissioning and provision of treatment. We have started informally canvassing opinion in the field about what we intend to be a major consultation shortly to update Models of Care for a new recovery era.

Our role is to work with our partners in health, criminal justice and local government to drive forward the detailed agenda set by the new administration. We all want drug addicts to get better and overcome their addiction, and anticipate continuing to promote recovery and reintegration within a balanced treatment system.

Paul Hayes is chief executive of the National Treatment Agency (NTA)

LETTERS

The greater the ignorance...

With reference to your articles on stigma (*DDN*, 15 February–26 April issues): Stigmatising is done to people by other people. People don't stigmatise themselves. Drug users are the most stigmatised group in societies across the world (Room R, *Stigma, social inequality and alcohol and drug use, Drug and Alcohol Review*, March 2005).

However, a troubled teenager is unlikely to say 'I won't use drugs if society is going to stigmatise me. The momentary stigma associated with drink driving is qualitatively a long way from the wholly stigmatised lives of problem drug users. Neil McKeganey's notion that to induce social stigma will somehow alter the behaviour of those seeking oblivion is disingenuous at best.

Social stigma is disapproval that intentionally provokes exclusion. Western society stigmatises drug use as it fears its consequences. Many of us have drink and drug use issues which, while not quite 'problematic', are close to being so. This large group includes fearful senior health professionals and media editors, who are among society's opinion formers.

All the while biomedicine stigmatises problem substance use as 'a chronic relapsing disorder' and editors sell newspapers on the back of traumatised and abused young people, stigma and its associated ignorance will persist.

Andy Ashenhurst, lecturer, psychology of dependence, University of Kent

On the Ning Nang Nong

Your recent article on matrix reimprinting (*DDN*, 26 April, page 12) does indeed require a paradigm shift. One that overturns the basic assumption that the scientific method has any value whatsoever.

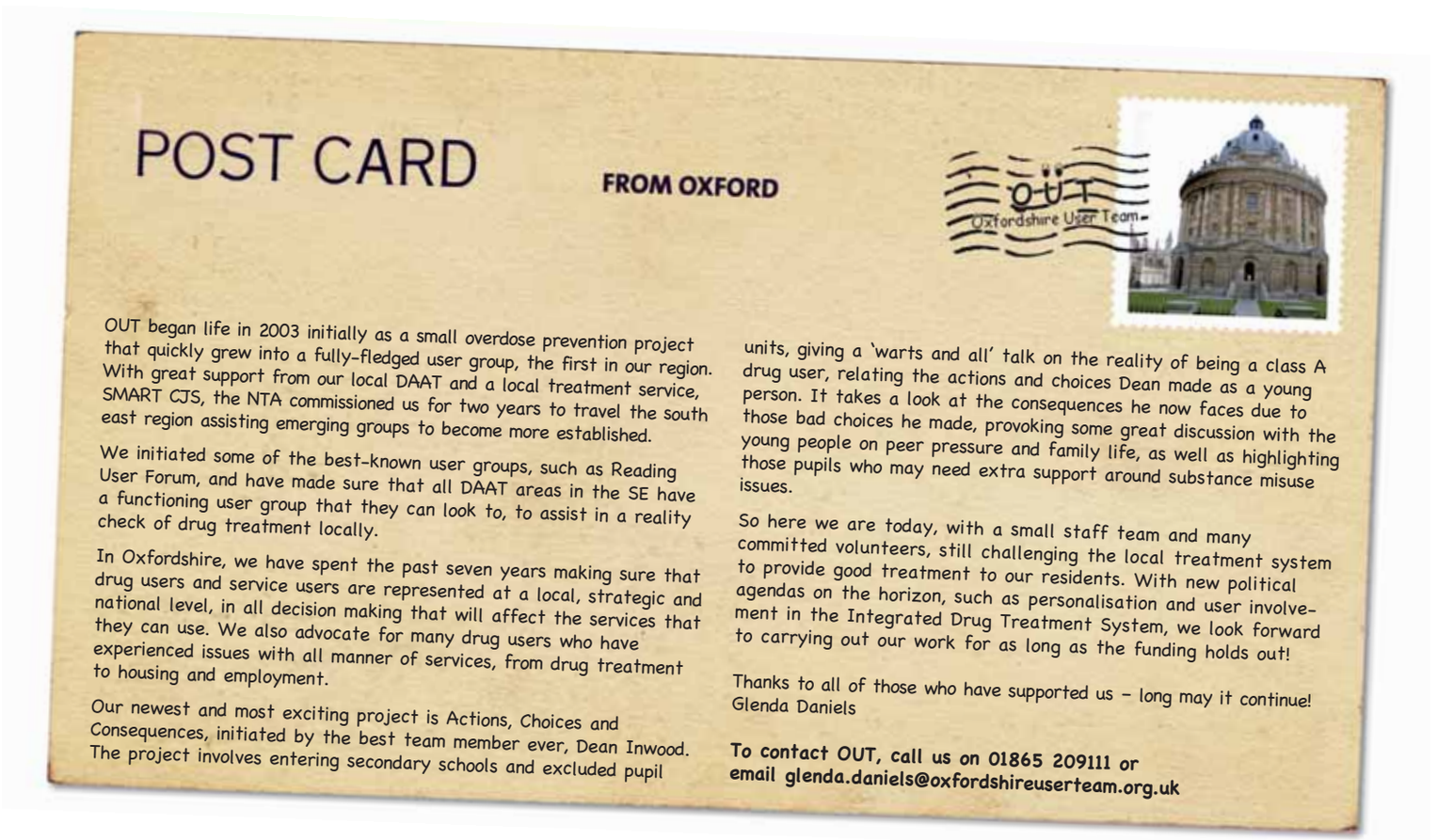
With this paradigm shift we can dip into cellular biology, neuroscience, quantum physics, epigenetics, Jungian psychology, and Sheldrake's morphic fields. Then, using techniques derived from Chinese acupuncture together with powerful questions, begin communication with the inner child by tapping into the subconscious messages stored in unified energy fields to rebalance the energy consciousness hologram.

This is the kind of far-fetched nonsense I would expect to stumble across on the internet as the result of an over-enthusiastic search engine, but was surprised to see it given the credibility of being the subject of an article in *DDN*.

Giles Wheatley, Dunoon

We welcome your letters...

Please email them to the editor, claire@cjwellings.com or post them to the address on page 3. Letters may be edited for space or clarity. Visit our forum at www.drinkanddrugsnews.com



POST CARD

FROM OXFORD

OUT
Oxfordshire User Team

OUT began life in 2003 initially as a small overdose prevention project that quickly grew into a fully-fledged user group, the first in our region. With great support from our local DAAT and a local treatment service, SMART CJS, the NTA commissioned us for two years to travel the south east region assisting emerging groups to become more established.

We initiated some of the best-known user groups, such as Reading User Forum, and have made sure that all DAAT areas in the SE have a functioning user group that they can look to, to assist in a reality check of drug treatment locally.

In Oxfordshire, we have spent the past seven years making sure that drug users and service users are represented at a local, strategic and national level, in all decision making that will affect the services that they can use. We also advocate for many drug users who have experienced issues with all manner of services, from drug treatment to housing and employment.

Our newest and most exciting project is Actions, Choices and Consequences, initiated by the best team member ever, Dean Inwood. The project involves entering secondary schools and excluded pupil units, giving a 'warts and all' talk on the reality of being a class A drug user, relating the actions and choices Dean made as a young person. It takes a look at the consequences he now faces due to those bad choices he made, provoking some great discussion with the young people on peer pressure and family life, as well as highlighting those pupils who may need extra support around substance misuse issues.

So here we are today, with a small staff team and many committed volunteers, still challenging the local treatment system to provide good treatment to our residents. With new political agendas on the horizon, such as personalisation and user involvement in the Integrated Drug Treatment System, we look forward to carrying out our work for as long as the funding holds out!

Thanks to all of those who have supported us – long may it continue!
Glenda Daniels

To contact OUT, call us on 01865 209111 or email glenda.daniels@oxfordshireuserteam.org.uk

Recipes for recovery

STARTING THEM YOUNG

A good diet is brainfood for children and adolescents and can keep them on track in later life, says Helen Sandwell

During a conversation with a drug treatment professional recently, we started to talk about the young people whom she dealt with in her work. Good diets are as important, if not more so, for growing young people as for fully developed adults, yet they are likely to be the most difficult group to engage with on this subject. Food tasting and cooking sessions are often the best way to keep a young group's interest, with the aim of demonstrating that healthy food can taste fine (if not great!).

The brain continues to develop through childhood and the adolescent years and it's likely that achieving the optimum balance of chemicals for the brain from the diet is even more crucial during this time than in adulthood. Certainly much of the research that has been conducted into how the diet can affect child behaviour and learning indicates that various components of the diet are significant factors. For example, consuming artificial food additives and inadequate dietary levels of omega-3 fats and zinc have all been found to significantly impact on hyperactive behaviour.

Research into foetal development is increasingly demonstrating that the maternal diet during pregnancy impacts on childhood and adult behaviour. We know that consuming alcohol and drugs during pregnancy can affect foetal development, giving rise to behavioural problems later in life. Likewise, specific maternal dietary excesses and deficiencies are now emerging as factors likely to mould a child's subsequent behaviour. Vitamin D in particular is interesting, since it's not only diet but also exposure to the sun that are important factors. Seasonal variations in vitamin D production in the skin may relate to the variation in seasonal birth rates of children who develop schizophrenia.

Maternal nutrition and the cognitive development of offspring is a relatively young area of research, and much is still to be found out. For example can damage incurred during foetal development be repaired later during childhood development, with adequate nutrition?

However, improving diets of those children and young people from underprivileged backgrounds who are most likely to have suffered from the results of poor maternal nutrition, and continuing poor nutrition through their lives is obviously of great importance. The former government recognised this with its Health in Pregnancy grants, Sure Start programme and related initiatives. Let's hope that whichever political party is governing when this is published will continue to do so.

Helen Sandwell is a freelance nutritionist. Her website is at www.goodfoodandhealth.co.uk. Helen's nutrition toolkit, giving healthy eating advice relating to substance use, is published by DDN on CD-rom – email charlotte@cjwellings.com for details.

Next generation of harm reduction

Professor Gerry Stimson looks to the future

The IHRA conference was a chance to engage in some nostalgia, but also to look forward to the next generation of harm reduction, said Professor Gerry Stimson, welcoming delegates to Liverpool for the 21st international harm reduction conference.

Harm reduction had begun in a modest way, with a drug users union in the Netherlands in 1984. Among the first needle exchanges in the UK was the Mersey Regional Drug Treatment Centre in Liverpool, not far from the conference venue. 'Who could have imagined that, 25 years later, harm reduction would have received such acceptance in the international community?,' he said.

Challenges for the next generation included expanding HIV related harm reduction into places where it was much needed and increasing pressures on international agencies such as the Global Fund to properly fund harm reduction.

'The next generation is about how harm reduction gets to grips with the way we control and regulate all psychoactive substances,' he said. 'Massive investment in law enforcement has not paid off.'

HIV interventions need urgent review

Bradley Mathers estimates that only five per cent of worldwide injecting is done with clean equipment

Interventions to combat the spread of HIV among injecting drug users needed to be scaled up dramatically, said Bradley Mathers of the University of New South Wales, reporting on the results of a global systematic review of efforts to expand HIV prevention. An estimated 3m IDUs were living with HIV, he said, half of whom were concentrated in Eastern Europe and South East Asia.

The review focused on needle and syringe programmes, opioid substitution therapy and antiretroviral therapy. Needle and syringe programmes were confirmed in 82 countries, he said, but this ranged from low to high coverage, the latter defined as 200 needles/syringes distributed per IDU per year. Most of the world fell into the 'low' category, however, of fewer than 100 needles per IDU per year – which meant 'potentially a large amount of HIV risk.' Globally, just 22 needles/syringes were distributed per IDU per year, he said, which meant that only around five per cent of worldwide injecting was done using clean equipment.

Opioid substitution therapy was present in 71 countries, but absent in around 80 countries where injecting occurs. Coverage remained low in most places and globally only eight people per 100 IDUs were receiving opioid substitution therapy, he told delegates. Worldwide, only four IDUs received antiretroviral therapy for every 100 HIV-positive injectors.

Interventions needed to be combined, he stressed: 'These interventions work best when delivered together – we need to scale them up, and we need to scale them up together.'

'Money talks' for policy change

Urban Weber encourages engagement with Global Fund recipients

'Once money is in the countries it starts to talk. Money from international donors can have a catalytic effect in changing policy.'

'There is not enough money out there for harm reduction' said Urban Weber, The Global Fund to Fight AIDS, Tuberculosis and Malaria's interim director for Eastern Europe, Central Asia, Middle East, North Africa, Latin America and the Caribbean. 'The Global Fund works through countries and therefore people need to engage in the countries that are recipients, so that more applications reach the Global Fund.'

So far Global Fund money remained unaffected by the financial crisis. 'Countries apply for programmes for a duration of up to five years and all the amounts approved by the Global Fund are secured at the time of approval,' he said. Replenishment of that money was occurring this year, with a pledging conference in October with Ban Ki-moon. 'The Global Fund will not get replenished because of harm reduction,' he said. 'It's because we're contributing to Millennium Development Goal number six – fighting HIV and malaria – as well as four and five, child mortality and maternal health. Harm reduction won't be prominent on the agenda, so it's piggy-backing harm reduction onto the larger picture.

'What's important is that the Global Fund fights the epidemic where it is, and 30 per cent of all HIV infections outside of sub-Saharan Africa occur because of the non-sterile use of injection material,' he added.

The conservative culture and politics of many developing nations meant it was unlikely that spending would come from domestic sources, making international donors vital. 'There's no other way to get money into these countries,' he said. But this money could lead to genuine policy change, he stressed, citing the Balkan countries and substitution treatment in Kyrgyzstan and Tajikistan. 'Once money is in the countries it starts to talk. Money from international donors can have a catalytic effect in changing policy.'

Youth Rise call for resources

Information, education and non-judgemental interventions needed

Lack of appropriate information and education is putting young people at risk according to representatives from Youth Rise, who made the case for non-judgemental interventions, tailored for the youth audience.

Most injecting drug users started practising before the age of 25, yet few HIV prevention programmes focused on youth, said Chantale Kallas, from the Lebanon (centre). Local data showed that 72 per cent of IDUs were less than 30 years old and more than 80 per cent shared needles. Nearly half of HIV infections related to young people aged 14 to 24, and 5.4m young people worldwide were infected with HIV.

Risky behaviour was linked to inadequate information and lack of access to health centres, and consultation led by UN groups called for a package of confidential adolescent-friendly services.

Harm reduction training and services were not being targeted on young people globally, according to Kyla Zanardi, Youth Rise's representative on HIV prevention.

With an estimated 6,000 new HIV infections each day among young people aged 15 to 24, her project aimed to provide free access to training and advocacy resources for young people on HIV and Aids prevention and substance use.

A 'youth engagement approach' was the guiding principle, complemented by adult partnerships, support and advice. Training had to be 'context-specific, flexible and creative', outlining best practice on harm reduction, HIV prevention, sexual health and substance use.

Three cents a day – the value of life

A new report details appalling lack of funding for global HIV harm reduction

Spending on harm reduction has to be increased urgently, according to a major new IHRA report. A 'cautious estimate' of the amount invested in HIV-related harm reduction in low- and middle-income countries in 2007 is approximately $160m, equating to $12.80 per injector per year, or three US cents per day, says *Three cents a day is not enough – resourcing HIV-related harm reduction on a global basis*. Furthermore, states the report, this is 'almost certainly' an overestimate of actual spending.

UNAIDS estimates the resources needed for harm reduction for 2010 at $3.2bn, or $256 per injector per year, figures which do not take into account additional resources for antiretroviral therapy, care and support. 'Current spending is clearly only a small proportion of that required and is nowhere near proportionate to need,' says the report.

Global funding for harm reduction is provided by 'a handful' of donor countries – 90 per cent of the $160m for 2007 came from donor contributions, while most major international philanthropic donors remain conspicuous by their absence from harm reduction funding. The report calls for more high-income countries to get involved in funding harm reduction if progress towards the goal of universal access to HIV prevention programmes – something the UN is committed to – is to be achieved for injecting drug users.

Donors should be able to set targets for the proportion of global spending going to HIV-related harm reduction, the report recommends, and IHRA wants to see this global spend properly monitored by UNAIDS and NGOs. Resources for harm reduction and HIV services for drug users should be proportionate to need within countries, it states, and a global community fund for harm reduction should be established to advocate for increased resources. The report also concludes that, given the scale of the funding gap, 'new ways of delivering harm reduction services' may be necessary.

'Rather than coming close to ensuring universal access, the current funding represents about one-twentieth of what is required,' states the document. 'People who use drugs are not receiving the harm reduction services that they need and to which they have a right. At current rates of progress, universal access to HIV prevention for people who inject drugs will not be achieved for decades, let alone in 2010. The scale of investment in harm reduction needs to be quickly and radically increased.'

Three cents a day is not enough, by Gerry V Stimson, Catherine Cook, Jamie Bridge, Javier Rio-Navarro, Rick Lines and Damon Barrett, available from www.ihra.net

Worldwide progress, in slow motion

Catherine Cook says we are moving in the right direction

This year's conference saw the launch of IHRA's report, *The global state of harm reduction 2010*, drawing together worldwide data.

'We've been looking at what's happened in terms of key interventions for harm reduction around the world, as well as how many countries have harm reduction within their national HIV or drug policies,' said report editor and IHRA senior analyst Catherine Cook.

Things were moving in the right direction but progress was very slow, she reported. 'To say a country has needle and syringe exchange doesn't necessarily give you an idea of how many people are being reached. There might be three needle and syringe exchange programmes serving 20,000 drug users.'

Ninety-three countries and territories around the world now supported harm reduction, 11 more than in 2008. 'By supporting harm reduction we mean they have it in their national policy documents or they have key interventions like needle exchange,' she said. Seventy countries now had opioid substitution therapy, an increase of seven since 2008.

Compiling the report had led to a sense of highly cautious optimism: 'There is movement, but it's way too slow and coverage is still very, very low – in most countries, not enough to have an impact on HIV or hepatitis C transmission.

'One of the things we did this time was commission people to write on areas of harm reduction that haven't been as well documented – hepatitis, TB, overdose and wider services, which in a sense are even less healthy than the response to HIV,' she added. 'We don't know as much about access, or how many people are affected, because there hasn't been the research or the drive we've had with the response to HIV, because that's where a lot of the money for harm reduction is. If you're looking for money to support overdose programmes, it's a much more difficult thing.'

Decriminalisation – Portugal shows the way

Alex Stevens explains that decriminalisation need not lead to increased drug use, if it's done properly

'What actually happens in practice when you decriminalise drugs?' asked Alex Stevens of the University of Kent. 'The argument that if you decriminalise it, it will lead to increased drug use is without any evidence, and Portugal is an example of this.'

Portugal had historically had low levels of overall drug use but high levels of injecting drug use and HIV, he said. A spike in drug-related deaths in the late 1990s prompted the government to establish a Multi-Disciplinary Commission on Drug Policy, which then fed into the 1999 National Drug Strategy.

One part of the 1999 strategy was the decriminalisation of all drugs for personal use – defined as up to ten days' supply. It became an administrative offence, rather than a criminal one, he said, with people referred to a panel to be assessed whether they were in need of treatment. The panel had the ability to impose fines, bans from public places and to revoke drivers' – and other – licences, but the most common outcome remained the deferment of any measures.

However, decriminalisation had gone hand in hand with expansion of both treatment services and the social security system, he stressed.

Since 2001 there had been small increases in reported illicit drug use among adults but reduced use among young people, as well as a reduced burden of drug offenders on the criminal justice system and reduced stigmatisation. There had also been increases in the amounts of drugs seized and a reduction in the retail price of drugs.

In 2000 there had been significant problems with prison overcrowding but since decriminalisation the number of drug law offenders had fallen from 44 per cent to 21 per cent. There had also been a fall in the number of prisoners using heroin in prison and 'very significant' reductions in infectious disease.

'Decriminalisation can reduce the infliction of drug law-related harms,' he said. 'It does not necessarily lead to increased harmful drug use, but treatment availability and wider social policy are at least as important as drug laws in determining levels of drug-related harm.'

Tackling the 'war on drugs'…

HOW COULD REGULATION LOOK?

'There is a broad consensus that the war on drugs has been a failure,' said Steve Rolles of Transform. However, there was 'only so far you can go' with decriminalisation.

'There's a clear line in the sand relating to production and supply – it's very absolutist. But the debate about what would happen if we were able to cross that line has been burning away for decades,' he said. This debate had been muddied by notions of 'heroin available in school vending machines and crack in corner shops, he said.

Transform's document *After the war on drugs: blueprint for regulation* painted a picture of what that world would look like, and was based on evidence and public health principles, he said. It spelled out five different models – medical prescription and/or subsidised use; a specialist pharmacist sales model; various forms of a licensed retail model; licensed premises for sales and consumption, and finally, unlicensed sales.

'…we've reached a really exciting phase in drug control.'

Genevieve Harris

LATITUDE OPENS DOORS

'As more and more states explore latitude for decriminalisation within the UN regime we've reached a really exciting phase in drug control,' said barrister Genevieve Harris.

The present system was based on three international conventions – beginning with the 1961 UN Single Convention on Narcotic drugs – that worked on the premise that drug addiction 'constitutes a serious evil and is fraught with medical and economic danger,' she said. Signatory states assumed legal obligations to implement drug controls.

The most relevant agency for overseeing the legal obligations was the International Narcotics Control Board (INCB), but this had little power to enforce, relying instead on 'sanctions and naming and shaming'. Offences broke down into two types – 'trafficking and commercial supply', which met with imprisonment, and 'personal use', for which there was more latitude.

The conventions deemed needle exchange, consumption rooms and substitute prescribing acceptable as long as they 'took place in a treatment context'.

TALK TO THE FARMERS

A disturbing international trend was seeing farmers as indistinguishable from combatants, according to political scientist Tom Kramer. 'The drug trade and politics are becoming intertwined. Drugs stimulate conflict and the other way round. If you're a poor farmer, opium is a good crop to grow because the buyers come to you.'

It was 'a myth' that opium in Afghanistan was only grown in conflict areas, while Burma was bucking the trend of declining opium production in Southeast Asia. 'The level of aid to Burma is one of the lowest in the world,' said Mr Kramer. 'There are staggering levels of poverty and an urgent need for alternative crops, as well as access to health and education.'

'In the 1980s and '90s, democracy in Columbia was propped up by the drug cartels and today land speculation is the problem,' said Columbian social justice activist Pedro Arenas. 'People who became very rich through drugs are buying land, so there's a new type of landlord in Columbia and they are influencing democratic channels. Many political parties have people funded by drug money. It's a very big problem – but how do you weed them out?'

Cambodians 'violate international law'

Human Rights Watch document an exponential rise in illegal arrest, detention and torture

'The compulsory drug treatment phenomenon is one that taints Southeast Asia,' said a spokesperson for Human Rights Watch, who didn't want to be named.

In January, Human Rights Watch had launched a report called *Skin on the cable – the illegal arrest, arbitrary detention and torture of people who use drugs in Cambodia*, which documented human rights violations against drug users. These included beatings, whippings, rapes and forced hard labour.

The number of people detained in these centres was rising exponentially, he said, with an increase of 40 per cent between 2008 and 2009. Around one in four of the detainees were under 18 – 'the centres are illegally detaining adults, children and the mentally ill. People are beaten, tortured and raped and there's nothing that approximates to what is recognised as drug treatment.'

Even 'given the flimsiness' of much of the legal structure in Cambodia, procedures were not being followed, he said – 'you never see an order from a prosecutor, judge or court'. People were being forced into detention either through 'massive police sweeps' or people paying the police to have their relatives arrested. 'These centres are operating extra-judicially, not within Cambodian law,' he said.

'...the centres are illegally detaining adults, children and the mentally ill. People are beaten, tortured and raped and there's nothing that approximates to what is recognised as drug treatment.'

One of the detainees interviewed for the report gave an account of whipping – 'on each whip the person's skin would come off and stick on the cable', hence the title of the report – in a centre in receipt of UNICEF support, Choam Chao. Detainees from other centres gave accounts of forced labour, coerced blood donation and people being rolled in barrels.

The report called for the Royal Government of Cambodia to immediately close all centres and expand community services, as well as investigate and hold to account those responsible for human rights violations. It also called on the international community to communicate that the system violates international and Cambodian law, request the closure of the centres and 'not legitimise them through engagement'.

Some states 'highly committed' to death penalty

Patrick Gallahue tells the conference that drug offences do not meet the standard of 'most serious crimes'

'On a legal analysis, the conversation is over,' said Patrick Gallahue of IHRA told delegates. 'It's been repeated time and again that drug offences do not meet the standard of "most serious crimes".'

Mr Gallahue was presenting the findings of the first country-by-country analysis of the death penalty for drug offences, due to be launched within the next month. Of 58 'retentionist' states, 32 retained legislation that prescribed the death penalty for drugs offences – however, 'active and aggressive' executors constituted a small minority of those countries. Five of the countries were considered abolitionist in practice, while others had the death penalty prescribed but did not use it – 'the vast majority only have such laws to appear to "get tough" on drugs.

'There's a small minority highly committed to the practice,' he continued. 'On our estimation, China, Iran, Saudi Arabia, Vietnam, Singapore and Malaysia.' Some 'educated guesses' had put the number of Chinese executions at 1,700 annually, many for drugs, while the figure for Iran in 2009 was 172 executions out of a total of 338. Saudi Arabia had executed 22 in 2008, the figure for Vietnam was unknown, and Singapore and Malaysia were 'down in recent years but traditionally they have been very, very harsh.

'There's no good news in all this, only degrees of bad, but progress is being made,' he continued. 'Only a small minority of states have actually brought the death penalty back for drug offences. The death penalty for drug offences is on the decline – it's an extreme position carried out by a small minority of states.'

Treatment or torture?

Richard Elliot questions whether compulsory treatment and negligent conduct constitues torture

International human rights law prohibited 'conduct that amounts to torture or cruel, inhuman or degrading treatment or punishment', said Richard Elliott of the Canadian HIV/Aids Legal Network. 'But when does the ill treatment of people in compulsory treatment amount to torture?'

In international law, prohibition extended to any detention, not just imprisonment, he said, and there were also codes of conduct for law enforcement officials and health professionals. There was a distinction in international law, he said – a four-part definition of torture. This was the infliction of 'severe pain and suffering'; 'intentionally inflicted on a person'; 'inflicted for such purposes as obtaining information, punishing, coercing or any reason based on discrimination' and 'at the instigation of, or with the consent or acquiescence of, a public official or other person in an official capacity'. 'One private person doing something horrific to someone else does not necessarily constitute torture under international law,' he said.

'If you can demonstrate negligent conduct on behalf of public officials – and that can be without specific purpose – it could fall under the banner "cruel and inhuman treatment or punishment",' he stressed. 'It's a lower bar than torture.

'Treatment is often imposed with the explicit or implicit objective of punishment for drug use or intimidation to deter people from drug use,' he said. 'If there is a link between treatment meted out and the aims and objectives of state, you could argue that this compulsory drug treatment is reflecting state policy and is not about medical assistance.'

Tobacco regulation hindering progress

Adrian Payne says the regulatory aspects of tobacco and nicotine do nothing to help harm reduction

The regulatory aspects of tobacco and nicotine were fragmented and did nothing to help harm reduction, according to Adrian Payne of Tobacco Horizons UK.

There were four building blocks of regulation – preventing onset, promoting cessation, protecting third parties and harm reduction. 'Failure to make use of the fourth is something we need to address,' he said. The WHO Framework Convention on Tobacco Control was the global policy framework, which sought increased access to pharmaceutical nicotine. 'But harm reduction doesn't figure, which is why it doesn't filter down to national policy. It's a missed opportunity.

'The real step change in risk is when you take away the smoke,' he said – smoke-free products were less harmful because the components of the smoke did the damage, not the nicotine itself. 'There's every reason to believe that smokeless tobacco products are vastly less harmful.'

However, regulatory barriers either existed or were being created to block the sale of smoke-free products. E-cigarettes replicated the hand-to-mouth motion of cigarettes and provided a vapour, he said – 'they're quite hi-tech and don't generate smoke.' However, there was pressure to move them under EU regulation to either the 'medical device' or 'medicinal product' category, both of which would take time and money, and some pressure groups even wanted them classified as tobacco products, 'which is weird because they don't actually contain any tobacco.' This move would put them under the auspices of the WHO framework and 'deprive people of products that are safer, and recreational rather than medicinal.

'It could cost lives,' he said. 'What do you say to people who smoke E-cigarettes – that "they're no longer available and you should go back to smoking cigarettes"?

'Current approaches are disjointed and counter-intuitive to harm reduction. Smokable products need to be evaluated on what benefits they can bring in relation to cigarettes. You have to give people options other than "quit or die".'

'SUPERIOR TO ABSTINENCE'

'Tobacco harm reduction is not only superior to forgoing harm reduction but it's also superior to promoting abstinence,' said Carl Phillips of TobaccoHarmReduction.org

'Cigarettes have a purchase price but they also have a health cost that people pay on top of that price. Tobacco harm reduction reduces that health cost by around 99 per cent. You still have to buy it, but it doesn't kill you – that's the value.'

The 'anti-smoking extremist position' was to simply reduce consumption, he said. 'It's the drug war mentality, which we know does not work. Looking at the total welfare, there's a much bigger surplus from using a low-risk alternative.'

MORALISTIC VIEWS

'The anti-smoking campaigns tend to resist tobacco harm reduction because the anti-tobacco movement is not purely about health,' said Chris Snowdon, author of *Velvet Glove, Iron Fist: a History of Anti-Smoking*.

Anti-tobacco movements went back centuries, with the substance historically being seen as 'ungodly, decadent and depraved'. Today the moral and puritanical element remained in anti-tobacco campaigning, he said, as could be seen with the moves to ban smoking outdoors – 'because it's seen as setting a bad example to others.'

'Modern anti-smoking activists are opposed to harm reduction because they tend to be idealists who can go on to become zealots' he commented. 'Good versus evil is for comic books rather than real world solutions. If the tobacco industry comes up with a less hazardous product then that should be seen as part of the solution instead of part of the problem.'

Conference special | Alcohol

Sustained action needed to tackle alcohol disorder

Karen Hughes describes how environmental factors impact drink-related violence

'A well-managed nightlife economy can bring a wide range of benefits, but is also a key location for a wide range of harms,' said Karen Hughes of Liverpool John Moores University. 'The UK is known for its heavy drinking culture.'

Researchers investigating alcohol use on a night out in the north west of England found that, on average, females were consuming 16 units of alcohol and males were consuming 25. 'An average bottle of wine is nine units,' she said. Nationally, one in five violent assaults occurred in or around pubs and clubs, and there was a very large disparity between the cost of alcohol in shops and its cost in licensed premises – 'it's three or four times cheaper than in pubs and clubs,' she said.

The UK government had recently banned irresponsible promotions in pubs and clubs but not in super-markets, she said, and there was a phenomenon of 'pre-loading' in many places, where people would drink before going out.

In terms of preventing drink-related violence, the way bars were managed and designed was critical, she stressed. Environmental factors associated with higher drunkenness included aggressive or inefficient staff, overcrowding, poor ventilation, lack of seating and loud noise.

Findings of a study as part of the Focus on Alcohol Safe Environments (FASE) initiative had shown that multi component community-based programmes could reduce harm in drinking environments, but behavioural, environmental and cultural factors could all mitigate this. 'One thing is certain, however – to be effective, action needs to be sustainable,' said Ms Hughes.

Enforcement agencies must embrace harm reduction

Why is enforcement still judged on seizures and arrests asked Nicola Singleton

There was now a widespread recognition that drug markets were resilient, said Nicola Singleton of the UK Drug Policy Commission (UKDPC). 'Enforcement has a real problem having any impact.'

'Harm exists at all levels – individual, family, community, national and international, not just in terms of health...'

Drug strategies were increasingly focused on reducing drug-related harms, she said, yet enforcement action was still largely judged on the number of people arrested and the amount of drugs seized – 'partly because those things are easy to measure'. However, the need to look at enforcement activities in terms of harm was becoming more widely recognised.

'When we talk about harm reduction the things that spring immediately to mind are needle exchange and substitute prescribing,' she said. 'But harm exists at all levels – individual, family, community, national and international – and not just in terms of health but social, economic, structural and environmental.' This broader approach gave a real opportunity for making an impact on harms, particularly regarding policing, she stressed.

Harm reduction often featured among the aims of operations – such as reducing public nuisance and acquisitive crime – but key measures remained the number of people arrested, and assessment of input on harms was rare, she said. However enforcement agencies generally accepted that enforcement would not eradicate drug markets, and that not all markets were equally harmful.

Traditional policing had a short-term focus, she suggested. 'For a sustained input you need a longer time frame.' Another issue was that classic police organisational structure was not well suited to community engagement and partnership working – however this was starting to change. 'There's a lot of good work underway and a lot of potential for taking a different approach in the future,' she said.

Crime drives poor treatment

Aram Barra relates a Mexican experience of the 'war on drugs'

An increase in drug-related violence in Mexico had driven the growth of drug treatment centres but compromised quality of care, according to Aram Barra, a long-time activist who had been working with Youth Rise.

The 'War on Drugs' had resulted in a 'decree', which modified general health law and the federal criminal code and aimed to differentiate between drug users, small time traffickers and the major drug traffickers, he explained. It included a table of maximum amounts that could be carried by a person, providing a compulsory route into drug treatment centres.

Fast growth of these 329 'new life' centres had meant that they lacked funding and had inadequate facilities inside.

'There is no systematic way of recording people coming into the centre, or whether their treatment has been successful,' said Mr Barra.

'Burden of the badge'

Soumen Mitra explains how his officers became 'more humane'

'There's a perception that "the burden of the badge" makes law enforcement officers insensitive to dealing with drug issues,' said Soumen Mitra, inspector general of the Calcutta police. However, he explained, his force had moved towards a more humane approach when dealing with drug issues.

'It's important that we come out of those stereotypes about drug users and sex workers,' he said 'Not only within the police but in the wider community.' The reality was that there was little coordination between the police, health authorities and NGOs, while another problem was the inability to amend archaic drug-related laws.

'This change has to come from legislators,' he said. 'Moving away from the archaic philosophy of the war on drugs means stepping out of traditional methods and building up awareness and training. Now we have a much more holistic and empathetic approach.'

COMPLEX SOLUTIONS

'What is alcohol harm reduction?' asked Rachel Herring of Middlesex University. 'A simple definition is measures that aim to reduce the negative consequences of drinking.' This did not just relate to consumption, she stressed, but also things like shatter-proof glassware.

The focus on the night-time economy had been on alcohol-related crime and disorder, acute health harms and youth binge drinking, she said. However, more recently this had widened out to include home drinking, middle aged and middle class 'hazardous and harmful' drinkers and broader health harms such as liver disease and heart disease.

MAKING LIVERPOOL SAFE

Traditional police responses to alcohol-related crime and disorder had been enforcement-led, one-dimensional and could suffer from a lack of capacity and resources, according to chief superintendent of Merseyside police, Stephen Watson.

'It's very much about joining the multi-component approach with other organisations and combining resources – if you've got the right mix of people you can have a tremendous impact.'

The city's community safety partnership, Citysafe, had harnessed a wide range of agencies including the police, the local authority, the health, fire and probation services, and housing providers, to achieve a 30 per cent reduction in levels of crime within four years.

CONFIDENCE TO INTERVENE

'Our goal is to educate all facets of society on the responsible sale and consumption of alcohol,' said Adam Chafetz of Washington DC-based TIPS. Founded in 1982, the organisation had certified more than 50,000 trainers and 3m servers worldwide and was now recognised as the standard for server training programmes in the US.

The obvious benefits of the training were to reduce alcohol-related problems, avoid serving underage people, minimise property damage by intoxicated people and 'protect your bottom line', he said – 'these people are in business and if you're going to work successfully with them you need to recognise that.'

Generational shift: Dutch users switch from injecting

John-Peter Kools: 'The challenge of the future is to get route transition onto the harm reduction agenda.'

'An entire generation of injectors in the Netherlands switched to non-injecting,' said independent drugs consultant John-Peter Kools.

Only 9 per cent of problem drug users were currently injecting in the Netherlands, but 20 years ago it had been a very different story. The Dutch 'heroin epidemic' had begun in the mid-1970s with 'bohemians and hippies' before expanding to unemployed youth, Surinamese migrants and people from other European countries with stricter drug laws. By 1985 there were 25,000 people using drugs in the Netherlands, 9,000 of them in Amsterdam. Forty per cent of the Dutch drug users were injecting, he said, along with 70 per cent of the migrants from other European countries. However, just 5 per cent of the Surinamese injected.

There was also 30 per cent HIV prevalence among IDUs in Amsterdam, he said. 'There was a distinct watershed between the injectors, who considered themselves the "real drug users", and the non-injectors, who were seen as "sissies". Health interventions aimed at prevention and cessation of injecting were needed, but the question was could it be done without alienating clients?'

However, the move from injecting to non-injecting did not begin with workers, he stressed – rather it was started among drug users themselves. 'The health promotion workers just recognised it, but it was then strengthened by health organisations.' One organisation even produced a magazine with health advice that contained high quality aluminium foil alongside articles on smoking heroin.

'This was an eye opener to a new trend for the injecting communities,' he said. A range of campaigns began with the objective of enforcing and accelerating existing trends of transition away from injection, with some needle exchange services providing aluminium foil. By 1995, field research showed that half of former injectors had moved away from injecting. 'The reasons were often very practical,' he said. 'Lots of people had vein problems and other logistical problems that led them to other ways of consuming drugs.' There were also peer support campaigns, such as a mobile counselling programme with outreach workers funded by the Ministry of Health.

'In a decade an entire generation of injectors stopped,' he said. 'It just went on and on. Injection prevalence has halved.' Only 4 per cent of Amsterdam drug users were current injectors, with 20 per cent reporting 'lifetime' use. HIV prevalence had fallen from 8.5 per cent to virtually zero, and the number of fatal overdoses had also drastically decreased.

'The challenge of the future is to get route transition onto the harm reduction agenda, not only in richer countries in Western Europe but in transitional and developing countries,' he said.

Taking initiatives to Eastern Europe

Neil Hunt describes *Break the cycle*, aimed at vulnerable youth

'We know the factors that influence whether people decide to inject,' said drugs researcher and consultant Neil Hunt. These included learning from, and watching, existing injectors.

He described work he had been involved in, investigating whether the *Break the cycle* intervention – designed to prevent initiation of injecting among vulnerable youth – would be appropriate in Serbia, Moldova and Albania. Serbia was 'not a poor country but not a rich one', he said, where 'people were very clear about the incredibly poor quality of heroin' – around 2 per cent. 'Novices would snort for a while, and it wasn't of a grade that was smokable. If you have a drug that can only be injected, you don't have a situation of mixing between injectors and non-injectors like in the UK.' It was also judged unrealistic to try and diminish social exposure among two of the most vulnerable populations in Serbia, street children and Roma.

Moldova, meanwhile, was a poorer country with the main injected drug home produced heroin known as 'shirka'. When the country's borders were first opened injecting was more visible and had carried some kudos, but social exposure to injecting had been reduced as it was now seen in a much more negative light, and there had also been increased police oppression. Initiating others was seen as highly taboo in Moldova – 'it was almost impossible to get people to talk about initiation,' he said. 'It's very unlikely that you're going to get conversations of the sort of quality necessary for the intervention, so it seemed the right decision not to proceed with it, and services had other priorities.'

In Albania, meanwhile, a lot of injecting took place in public areas, and services – while often poorly resourced – had a strong ethos of developing outreach work with peers from the local community. Heroin purity was sufficiently good to sustain sniffing, smoking or injecting, he said, and therefore there was more mixing between injecting and non-injecting heroin users, making it a more appropriate environment to offer *Break the cycle*.

'Transition to injecting is not automatic,' he said. 'We're now in the process of translating the campaign materials and testing them with local injectors.'

Drug users – equal partners

Mat Southwell celebrates European models

Europe had been a champion for harm reduction and the catalyst for models of harm reduction that had since gone on to be adopted around the world as best practice, said Mat Southwell of INPUD (the International Network of People who Use Drugs). The challenge was to scale that up around the world.

'It cannot be right that in Europe we can have life-saving strategies to protect people who use drugs, while in Russia there are thousands of heroin-related deaths every year'. In the fierce debates at places such as the Commission on Narcotic Drugs, the EU was central to fighting harm reduction's corner, such as when 26 countries under the leadership of Germany stated that HIV prevention meant harm reduction. 'It's important that we see the increasing discomfort in what's called the "unintended consequences" of drug control,' he said.

Harm reduction's move to the mainstream did not mean there was not still substantial reticence – while people may accept many of the core harm reduction functions, they could remain ambivalent about things such as consumption rooms, heroin prescribing and crack pipe distribution. 'The evidence of harm reduction is overwhelming,' he said. 'It's dogma that prevents us from implementing it.'

The conference would also see the launch of the European Harm Reduction Network, following the approval of EU funding last year, he said. The network would be driven by science and would share best practice and learning as well as encourage members to challenge each other.

‘Keep working for justice’

Julian Buchanan realised he was setting up people to fail

Harm reduction on Merseyside had begun in 1985 when heroin was an emerging problem, said Julian Buchanan of Glyndwr University. ‘I was a probation officer at the time and we weren’t really clear what to do,’ he said. ‘So I embraced the received wisdom of the time.’

This amounted to action to ‘encourage, persuade and pressurise change’, he said. ‘After months of adopting this abstinence-based strategy I realised it wasn’t working, that I was setting up people to fail, and that I’d abandoned a number of basic principles from my social work training. It was important to go back to these – principles that didn’t seem to apply when working with drug users.’ These included listening, understanding, empathy, respect, being non-judgmental and giving the client space, he said.

It proved hard to change the practices of the time, however, so a number of professionals eventually formalised into a group that included a psychiatrist, a probation officer, psychiatric nurses, social services counsellors and an Aids outreach worker.

‘There was a climate for change. Not because people cared about drug users particularly, but because the panic around HIV and Aids opened the door to a more humane approach,’ he said.

Harm reduction ‘shouldn’t be God’

Stanton Peele: It’s not the drug it’s the relationship a person has with the drug

‘We all know people who can’t quit their addictions. That’s not the drug, it’s the relationship the person has with the drug,’ said psychologist Stanton Peele. In the 1980s, half of US smokers had quit, ‘95 per cent of them cold turkey’ he said. ‘These days 65 per cent do it on their own.

‘God didn’t chisel addiction in stone,’ he continued. ‘Thinking affects addiction, and harm reduction shouldn’t be God. Methadone maintenance may say to a person “you were born to be a heroin addict”. Harm reduction should not be in the position of selling to people that they may have a lifetime of addiction. Don’t reify yourselves into godlike status and say “you can’t quit your addiction so use something we give you as your only alternative”. I’m for harm reduction – but only human beings can overcome addiction.’

Theory helps us ‘stop making it up as we go along’

Russell Newcombe maps out the philosophical territory

‘Why do we need a theory of harm reduction?’ asked Russell Newcombe of Liverpool John Moore’s University. ‘Because it improves communication between agencies, helps develop policies and interventions, and helps map out the territory. In short, it helps us stop making it up as we go along.’

Core concepts were causes of drug use, consumption and consequences, he said. Levels of risk indicated the ‘general propensity of a behaviour for producing a particular harmful consequence, such as overdose’. Different classes of drug-related risk were drug, set – *ie* ‘body and mind’ – and setting, which included place and time but also drug policy. He had developed a risk CAMP MAP, he told the conference, which stood for Context, Amount, Method (preparation and administration), Pattern (frequency and stability), Mixture (poly-drug use), Access (where the drugs were obtained) and Product (the chemistry of the drug itself).

The consequences of drug use were ‘harms and benefits’, he said. ‘Drug use has benefits. You know that because you all use drugs of one sort or another.’ Harm/benefit occurred at individual, community and societal level, and could be divided into health, societal and economic categories. Harm reduction interventions, meanwhile, could be split into three categories – risk prevention, such as clean needles, harm prevention, such as HBV vaccines, and harm containment, such as HBV treatment. ‘We also need to think about measures of effectiveness,’ he said. ‘Magnitude of change can be measured three levels – prevalence, frequency and intensity.’

‘Why do we need a theory of harm reduction? Because it improves communication between agencies, helps develop policies and interventions...’

■ **Issues of the Daily Update, the IHRA conference paper produced by the DDN team for each day of the event, are available on our website, www.drinkanddrugsnews.com**

Can our treatment system survive a 'policy crisis'?

The debate of the moment, Steve Hamer introduces three speakers: Roger Howard, Nick Barton and Prof Neil McKeganey

Understanding of treatment has grown over the last 25 years, but now the system's creaking somewhat, said Steve Hamer of Compass (left), chairing a much-anticipated debate in the conference 'dialogue space'.

'The debate gets polarised as if harm reduction and abstinence can't co-exist,' he commented, inviting three speakers to debate the future of harm reduction in a recovery-oriented climate.

'Are we experiencing a policy crisis at the moment?,' asked Roger Howard (second left) of the UKDPC. There were many different crises being suggested – a crisis about people being 'parked' on methadone, a crisis of ideology, a crisis that 'recovery' is gaining centre stage.

'Personally I don't think drug treatment or the treatment system are in crisis – it's just a natural stage of the cycle,' he said. 'We had to face up to the reality of there being less money around, so ministers would be looking very closely at the treatment system.

'The trouble with public health gains is that they're long term. Crime reduction pushes ministers' buttons,' he said. With relapse rates 'worryingly high', the UKDPC had been pressing the need for wraparound services.

The notion of recovery 'as a new organising paradigm' had been gaining momentum, driven by the user self-help movement. 'We have to make sure that recovery doesn't just mean abstinence,' he said.

Nick Barton, chief executive of Action on Addiction (second right), commented that if you worked in the harm reduction field it was often assumed you had 'no truck' with recovery and abstinence-based treatment. But he came to the debate from 'a passionate and dispassionate viewpoint' as his organisation ran a diverse range of services.

What he did find depressing, he said, was that an article he wrote years ago, calling for an end to polarisation in favour of the common goal of helping build healthy and fulfilling lives, was still relevant today.

'This won't happen until each party looks at its own deficiencies instead of pointing the finger excitedly at the failings of the other,' he said. 'The aspirations of the client can be overlooked.'

'The answer is in recasting the shared goal,' he added. 'And that goal should be maximising wellbeing and quality of life.'

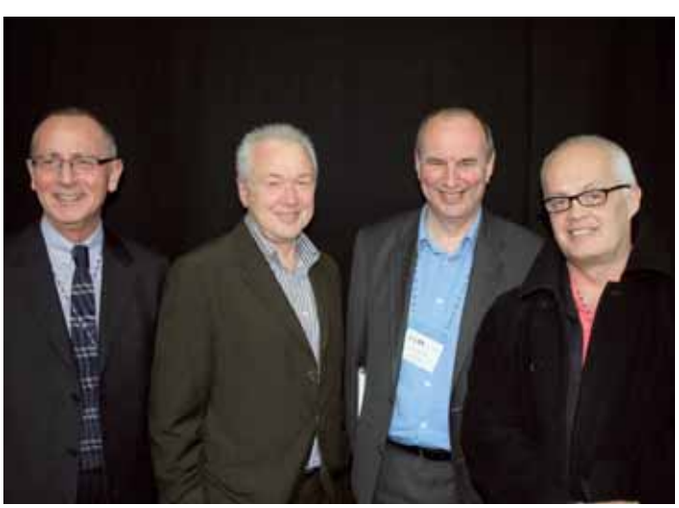
'It's unusual for me to speak at this conference as my voice is seen as critical,' said the final speaker, Prof Neil McKeganey from the Centre for Drug Misuse Research at Glasgow University.

'I'm seen as signalling something akin to a crisis and disrupting an otherwise comfortable consensus around treatment,' he said. 'Questioning what treatment's for has become sacrilege. Yet achievements of drug treatment are so modest – to raise the quality of treatment it's right that we ask fundamental questions.'

When asking people in treatment what they wanted, they said 'to be drug free' – but this wasn't happening. Less than five per cent became drug free, 'and that's not something to be proud of' he said.

Methadone maintenance had become 'hallowed territory – we are expected to universally celebrate the success of methadone,' he said. 'But go to a methadone clinic and you won't find the children of the wealthy. You'll find them in residential rehab. Methadone is the treatment for the masses.'

'We should have a treatment world in the UK which is aspirational for its clients, rather than continued reliance on a highly addictive medication. Yet to express these views is unwelcome,' he added. 'There's a scandalous lack of resources to help people become drug free.'



'Questioning what treatment's for has become sacrilege. Yet achievements of drug treatment are so modest – to raise the quality of treatment it's right that we ask fundamental questions.'

And the audience said...

'I don't believe there's a high-level methadone conspiracy to do down residential rehab. There has been a lot of campaigning for tier 4 treatment to get a larger share of the pooled treatment budget.'
HARRY SHAPIRO, DRUGSCOPE

'This idea that drug workers and nurses just give out prescriptions is simply not accurate. Please don't tar harm reduction workers with this brush of being happy to draw salaries at the expense of service users. It's extremely emotive stuff.'
CLAIRE ROBBINS, CLINICAL NURSE SPECIALIST

'This debate reminds me of how self-critical we are. Drug treatment has saved many lives, reduced crime and has been the envy of much of Europe when it comes to tackling HIV. We shouldn't forget the great achievements of drug treatment in this country.'
PAOLO PERTICA, DAAT COORDINATOR

'We're not worried about the fact that the media is talking about these things. The worry is about how the media in this country treats the methadone debate – it's a debate that doesn't include harm reduction, just having a substance in a person's body.'
DAMON BARRETT, IHRA

'There's a lot of policy conflict in this country. We're expecting people to move forward and integrate and yet the Welfare Reform Act makes it hard for people to move away from that benefit culture.'
CLIVE EMMETT, WDP

'We've had the reclassification of cannabis and appalling public support for sterilising drug users – the way the debate is coming out in the media is playing to the gut reactions of the public and politicians. The problem is how do we keep drug treatment on an evidence basis.'
HARRY SHAPIRO, DRUGSCOPE

'In all likelihood we're going to see a change of policy and we have to be careful about the most vulnerable people, those with complex health problems. We'll see people moving towards the quick wins, and that's where the money will be attached. The most vulnerable people won't benefit from that.'
JIM McVEIGH, LIVERPOOL JOHN MOORE'S UNIVERSITY

The show must go on

Organising a conference for more than 1,000 delegates from all over the world is never an easy task – let alone when delegates and speakers are confronted by the travel disruption from volcanic ash. Paddy Costall (pictured, centre) found a moment to share his thoughts in the final chaotic countdown to the event

'You don't want to fill people's day from the moment they take their head off the pillow until their head hits the pillow again at night. I've been to places where it's a badge of honour to go to something from seven in the morning until 11 at night. But I'm not the George S Patten of conference organisation – I don't believe people should die for it.'

On Sunday 25 April IHRA began welcoming delegates through the doors of the Echo Arena in Liverpool. For Paddy Costall, managing director of the Conference Consortium which organised the event, it was the culmination of more than a year's hard work and many meetings – and time to breathe a sigh of relief that most delegates had made it.

Coming from a professional background in the drugs, alcohol and criminal justice field, Mr Costall first became involved in the IHRA conference in 2007 as director of services at Cranstoun, which at the time managed the European Network on Drugs and Infections in Prisons (ENDIP). When ENDIP got involved in a joint bid with the fledgling Conference Consortium to run the event in Warsaw, it was natural that he should find himself in the organiser's shoes, as he was a key figure in developing the Consortium.

It was the beginning of a long-term relationship between IHRA and the Consortium, which would see the conference arrive at Barcelona, Bangkok (during a state of emergency for the country!) and Liverpool.

'The Consortium brings continuity and stability for IHRA in the way the conference is delivered', explained Mr Costall. 'Our strategic development gives IHRA even greater scope to develop a diverse and inclusive programme year on year. It goes hand in hand with the expansion of IHRA's work on behalf of the Department of International Development.'

'It's an incredibly challenging event to put on,' he added, 'but people have a real investment and get a real kick out of making it work.' Working with his multi-lingual team, he arranged translation into at least two languages other than English. 'This year we have Russian to maintain our constituency from Central and Eastern Europe, and French for the large number of French-speaking countries and for the target group of Middle East and North Africa, where we're taking the conference next year.

The content of the event has taken another step forward to keep up with delegates' expectations. There is more filming, including of poster presentations, the launch of the International Harm Reduction Academy, and an interactive 'dialogue space' to make the exhibition area 'a real living part of the conference'.

'We try to mould the conference around the needs of the people who attend it,' said Mr Costall, and this principle guided the way the entire programme was put together. Sessions were run in manageable time slots to the framework of a working day, with frequent refreshment breaks. Alongside providing adequate variety, he was very conscious of not wanting to overpack the programme.

With six hours of solid programme content each day, plus the opportunity to network onsite (and offsite, with the assistance of the local Mersey Partnership), he was aware of the difficult balance: 'You don't want to fill people's day from the moment they take their head off the pillow until their head hits the pillow again at night. I've been to places where it's a badge of honour to go to something from seven in the morning until 11 at night. But I'm not the George S Patten of conference organisation – I don't believe people should die for it.'

He hoped people would come away from the conference with the feeling they'd learned something, he said. But above all, he wanted them to enjoy it and participate fully in what he believes has become an 'influential global village' more than a conference.

'I always remember what Patrick O'Hare [conference founder] said to me in Vancouver at the 2006 conference, when I was thinking about the enormity of the task of doing it in Warsaw,' he recalled. 'He said "whatever you do Paddy, never forget we're in showbusiness! And if people aren't happy, they won't come back."'

CENTRE STAGE

The SMMGP's recent conference in Glasgow included the topic *Harm reduction – everyone's business*. **DDN** hears from the session's four speakers

Peter McDermott,
The Alliance: Keeping harm reduction in recovery

A dominant characteristic of the drugs field is the extent to which it has been driven by ideology and personal prejudice. Because addiction is a chronic and relapsing condition, progress often appears slow – and sometimes people appear to be going backwards. Consequently, some people have a tendency to become overly wedded to the particular modality that happened to work for them or a friend or family member.

Science is the antidote to this magical thinking, and the last decade has seen a growing reliance on the evidence base. Recently though, fashions have shifted once again, and 'recovery fever' is upon us. Unlike other conditions, in addictions the word 'recovery' is often used to refer solely to the state of total abstinence, and we're now seeing political battles over treatment modalities – something that politicians once left to the expert consensus.

While arguments between the recovery lobby and those who support a balanced system have often been somewhat bitter and acrimonious, there is a kernel of value in the critique that some recovery advocates have made. For the last year or so, The Alliance has seconded me to work at Sefton DAT on their systems change pilot. One of the first tasks was a user-led needs assessment and some of our findings surprised me. For example, most people claimed that they sought drug treatment to become drug free, and some felt the system was somehow 'capturing' them through the use of substitute prescribing. Most people who didn't seek treatment avoided it because they felt substitute prescribing was all that was available, while people not in treatment felt it would take about six months to become drug free. People in treatment felt it would take five years or more.

The treatment system seems to be failing to meet the ambitions and aspirations of some who use it. Of course, these findings may be attributable to other factors. Those in treatment for protracted periods may have more severe dependence and associated social problems, but Sefton are now attempting to reconfigure their treatment system to more actively attempt to meet those aspirations, in part by making the abstinence pathways more transparent and access to those pathways fairer.

Nevertheless, addiction treatment still lacks a 'magic bullet'. Abstinence-based modalities have the same rates of relapse that they always did, and the need for harm reduction-based interventions that keep people safe and alive is just as strong as it always has been. The evidence overwhelmingly shows that failure to provide interventions like needle exchange and methadone maintenance will result in increases in transmission of blood-borne viruses, drug related deaths, crime and other morbidity. We forget these truths at our peril.

Roy Robertson,
GP and reader at Edinburgh University: The way forward for primary care

General practice, or more precisely the team approach provided in primary care, is the natural home for a harm minimisation philosophy. The structures and systems in primary care and the liaisons with a wide range of specialist services make it resource intensive and, perhaps more importantly, able to deal with all aspects of dependency and the consequences of illegal drug use. The primary as well as secondary disease prevention approach in primary care is familiar in cardiovascular disease as well as chronic conditions such as diabetes, and fits very well with enduring disorders like addictions.

Our recent research has added a further emphasis to the strength of general practice – longitudinal care and contact with people who have a longstanding remitting and relapsing disorder. A recent follow up study of nearly 800 individuals who have injected opiates shows that opiate substitute treatment is required over many years if not indefinitely. This is not something that surprises most long-term observers of treatment services but nevertheless the reality of lifelong treatments and support are often unacceptable to politicians and not accounted for by public health and funding agencies.

Case studies in our practice also show the serious medical consequences of injecting drug use and, as this population ages the accumulation of associated disorders become more and more important. The study demonstrated the high mortality due to blood borne viruses and the fact that, even in those without HIV/Aids, 50 per cent were dead by middle age. Many other conditions and complications shorten the lives of injecting drug users – hepatitis C, endocarditis, anthrax, overdose, mental health problems, alcoholic cardiomyopathy, liver disease and, increasingly, early pulmonary disorders in excessively heavy smokers are regular features in any practice with a caseload of drug dependent patients.

Treatment with a range of interventions, including opiate substitute prescriptions, have been shown to work and in our study prevented deaths over a long time period. These treatments should be unreservedly made available to those who need them. Methadone and other opiate substitute treatment is not incompatible with the recovery agenda and, indeed, the stability provided by these prescriptions makes an excellent platform for lifestyle improvements and social development.

Sara McGrail and **David MacKintosh**,
independent consultants: Time to redefine harm reduction

Harm reduction is not simply about needles and methadone. It embraces supply reduction, policing, legal status and community policy, and is often characterised by a person-centred approach – working with people towards realistic achievable goals and helping them deal with a range of needs.

HIV/Aids meant that harm reduction became the framework for all new investment in drug treatment and the cornerstone of the development of pragmatic, community- and individual-focused drug strategy. An important concept was established – 'we need to do what works'. This pragmatism allowed discussions to be held around a table with our political masters and other local partners and enabled things to get done – it could diffuse even the most rabid local councillor.

But complacency set in. While harm reduction was still a part of our approach it began to be redefined and moved from centre stage. By 2002, two critical issues were facing the drugs field – establishing a treatment sector that was fit for purpose and finding some way of securing the financial and political commitment to allow this to happen. Harm reduction began to change its shape to fit these objectives.

Health – specifically public health – no longer had the compelling political argument necessary to drive investment. But crime did. Harm reduction was redefined as disease and crime prevention and the joined up community wide solutions that had been the focus of so many of our successes around HIV began to fall away. We narrowed the focus of our work – arguably everywhere except in general practice and the few tier two projects that withstood the performance management system.

'Unlike other conditions, in addictions the word 'recovery' is often used to refer solely to the state of total abstinence, and we're now seeing political battles over treatment modalities – something that politicians once left to the expert consensus.'

There are now far greater numbers of people in treatment. We have a treatment sector that has grown massively since 1997, with thousands more drug workers, the NICE guidance, the updated Orange book and waiting times that sit at not more than four weeks in almost every area. So does it matter that harm reduction has been sidelined and ever more narrowly defined?

Well, yes. Health Protection Agency (HPA) figures show that we took our eye off the harm reduction ball. The rate of hepatitis C infection among naïve injectors is a denouncement of failures to act and respond to emerging situations. There is a need for peer education and a lack of knowledge, not just about how to try and avoid infection but around accessing treatment and people taking care of themselves. This is a major public health problem, one that we have taken over a decade to respond effectively to. Even the economic argument for interventions – heading off a massive looming cost – has not galvanised the system into effective action. By 2015 the HPA estimates there will be 10,950 people with cancer or cirrhosis related to hepatitis C.

A rough comparison of a 1997 needle exchange survey and what has been published of the NTA survey of needle exchange from 2006 indicates that, while distribution of needles has remained more or less static, the variety of equipment available and the number of additional services available with that equipment has shrunk significantly. Reports from drug users and providers bear this out, indicating that while greater availability of pharmacy exchange is welcome it seems to have come at the expense of free-standing programmes providing immunisation, social and healthcare interventions, advice, support and pathways into treatment.

The recent deaths relating to anthrax-contaminated heroin is a study in how we have lost the urgency, understanding and determination to reduce harm that was characteristic of the 1980s and '90s. Harm reduction should not be a sideshow, nor should we allow it to be cast as an approach that is anti-recovery or anti-abstinence. Indeed recovery and abstinence goals fit within a humane and holistic approach to helping individuals, families and communities reduce the harm that drugs can cause. The recovery movement has been cast as a reaction against harm reduction but is surely more a reaction against the deterministic, criminal justice target heavy drug strategy and apparatus we have developed in the last decade.

Harm reduction will return – because it works, because it's pragmatic. We just have to hope it's not driven by a full-blown public health crisis. It's about more than national policy – it's about good practice locally, giving politicians confidence and promoting work that is saving lives, improving health and helping raise the quality of life for entire communities.

We must not allow those with political axes to grind or snake oil to sell obscure a fundamental truth. It's ironic that while national government and health leads have avoided the term 'harm reduction' it has gained currency within law enforcement. General practice, primary care, universal and low threshold services have a vital role to play. Harm reduction has achieved much that we in the UK should be proud of. It's time to redefine harm reduction as the essence, the key to what we all do and aim to achieve.

Hilary Henriques: 'An opening can be created for a teachable moment, to inspire the belief that "I can do it"... Be an enlightened witness. Just be there. We talk too much about doing – we make most difference by simply being there when children need us or want us.'

COME TOGETHER

A family's desire for things to be back to 'normal' can mean unrealistic expectations of treatment and a misunderstanding of harm reduction's aims. **Dawn Love** and **Esther Harris** of DHI describe how their service is addressing the issue

Harm reduction services and families are often perceived as being in conflict with each other. This year's *Reach out* conference in March, organised by the Drugs and Homeless Initiative (DHI), sought to bring the two together under one roof to give families and carers the opportunity to voice concerns, share experiences and meet professionals working with drug users.

For a long time there was little support available for families. Now, services like our 'Families Also Matter' initiative can provide this support to people who have previously been trying to manage their problems in isolation. But families can be unaware that recovery is a process, not an event, which means that expectations of the treatment process can sometimes be unrealistic, and families might feel anxious, frustrated and disappointed that the situation is not resolved quickly.

Harm reduction services can often be a focus for this frustration. When family members discover that their relation is, for instance, being given clean needles and syringes they may feel that services are 'allowing' drug use to continue and prolonging their ordeal. Therefore 'Families Also Matter' provides advice and information which increases understanding and awareness of the treatment process. It can be equally challenging for families of anyone drinking problematically – the anticipation is often that services can 'make' loved ones stop drinking and families are sometimes bewildered to discover that, where appropriate, people might initially be supported to reduce and control their alcohol intake.

The provision of naloxone is still seen as controversial by some families and carers because of the perception that it colludes with illicit drug use. Jody Clark, DHI's harm reduction co-ordinator, explained how they have been delivering an overdose prevention and response programme since 2007 in partnership with the Red Cross and Bristol Specialist Drug and Alcohol Service. The aim is to reduce the risk of heroin overdose, but also to train drug users to respond appropriately and confidently should it occur.

The training includes the distribution of naloxone, which allows time for an ambulance to be called and lives to be saved. To date there have been seven reported uses of naloxone in South Gloucestershire and probably seven deaths avoided. In 2009 the project received the British Red Cross Excellence Award for partnership working, and families, carers and friends can become involved in the next stage of the programme by being trained to recognise the signs of overdose and administer naloxone themselves.

In response to a conference breakout session on overdose prevention and response training by harm reduction workers Andre Traile and Ed Holder, one participant asked 'Why weren't we offered this training years ago?'

Harm reduction isn't only targeted at the drug or alcohol user in the family. As the keynote speaker at our event, Hilary Henriques of the National Association for Children of Alcoholics (NACOA) explained how her organisation started as a response to an obvious need.

'The family colludes to keep their problems secret from the outside world in an effort to keep their families together and "safe",' she told the conference. 'And lost in the rearrangement of family life to accommodate the elephant in the room were the children'. Seeing children sometimes 'dragged along' to family meetings, frightened to say the wrong thing and to let anyone know that things were far from perfect at home, NACOA sought to begin to empower children with life skills to help them cope with difficult challenges.

Callers to NACOA's helpline, of which there have been over 140,000, describe living with unpredictable behaviour, being abused or ignored, witnessing violence and how it feels to be frightened on a daily basis. Hilary illustrated how a prolonged period of inconsistent care and the unmet wish for attention, security and affection can result in a child's needs being misdirected – sometimes resulting in aggression, eating problems, self harm and substance use.

NACOA can address some of this harm, not just by listening to children, but by helping them develop new, positive beliefs about themselves and learn effective ways to cope with their problems. 'An opening can be created for a teachable moment, to inspire the belief that "I can do it",' she said. The presence of caring adults can also play an important role in the child's development and success in later life. 'This is what NACOA provides, and you can too. Be an enlightened witness. Just be there. We talk too much about doing – we make most difference by simply being there when children need us or want us.'

Irene MacDonald described how, two years after her own son died as the result of a drug overdose, she found herself volunteering in the needle exchange of her local drug service. When she and her husband were living alongside their son's drug use, they were prompted to start the Cheltenham Parent Support Group. After her son's death Irene began to want more of an insight into what had happened to him, and her research and study led her to develop an interest in treatment services. She decided to volunteer with the local service – she hadn't anticipated working in a needle exchange.

'As the parent of a heroin user, the thought that my son could go to such a place and be handed needles with which to inject filled me with horror,' she explained. 'There was I, doing my best to get him to stop using, when on the other side of town there was a service giving him the equipment he needed to do it with.' She admitted that she had firmly believed that if needle and syringe exchanges didn't exist people would have to stop injecting drugs. 'How blinkered was that? At the time it seemed like a reasonable argument to me. I never gave a thought to the fact he might share and re-use needles, or that he might inject anywhere other than his arms.'

Irene told the conference about the funeral of another young heroin user that she attended last year. Explaining to a friend that she had to rush back as she was 'on duty' in the needle exchange, she was regarded with horror and asked how she could go back there after what she had seen that day? 'Without thinking about it, I heard myself saying "because I truly believe it is the right thing". This was coming from me, a woman who had wanted all needle exchanges closed down, so what had changed my mind? Actually knowing why we have this service, how it works and what it achieves.'

As drug and alcohol treatment professionals we know that families, carers and harm reduction services all want the best outcome for the drug and alcohol user. This conference demonstrated the imaginative and practical ways that this is already happening and looked forward to a future of positive collaboration.

Reach out 2011 is planned as a two-day event in Bristol on March 25-26.

Dawn Love is director (clinical lead), DHI. Esther Harris is family practitioner, DHI (South Gloucestershire). Contact esther.harris@southglos.gov.uk for more information. www.drugsandhomeless.org.uk

Notes from the Alliance

Justice for fathers

Family support systems and treatment outcome monitoring must take more notice of dads, argues *Daren Garratt*

'THINKING FAMILY' within the wider recovery and reintegration agenda has rightly become an increasing political and operational priority in recent years. But can we honestly say that effective care planning and treatment outcome monitoring has been encouraged to 'think father'?

In essence, this is just a subtle yet significant development of the current drug strategy aim to 'support parents with substance misuse problems' as it reflects the cultural sea change requiring all services to respond effectively and systematically to the needs of fathers – but how many services genuinely do that? The Fatherhood Institute *Dad's test* (2009) identifies that often, when dads read the word 'parent' they assume it means 'mother', and it has long concerned me that we need to acknowledge and accept this concept in the wider, generic worlds of public health and criminal justice. We need to innovate work that concentrates on the impact that positive or negative treatment experiences can have on a dad's ability to parent.

Reaching out: think family – analysis and themes from the families at risk review (Social Exclusion Task Force, June 2007) acknowledges that 'the tailored whole families approach requires a shift in the mindset of professionals at all levels and the challenges of this should not be underestimated' (page 54). It encourages our workforce to look beyond the relatively simplistic 'drug user' status of clients and begin to contextualise their wider reintegration needs. Their role as parents will be one of the major challenges we will face when attempting to embed Think Family and Safeguarding Children approaches within recovery-oriented drug treatment systems across local drug treatment partnerships.

It has long been recognised that our target-driven culture requires services to address the specific needs of certain priority groups, yet dads are rarely factored into this. The new drug strategy rightly places a clear focus on supporting 'families', but most of the research and targeted interventions are around women users, while the majority of those in treatment services are men. There remains, therefore, a clear need to explore how effective, integrated support systems can impact on an individual's parenting role and the wider wellbeing of the family.

I truly believe that identifying, encouraging and supporting service users and prisoners in their parental role can only improve family cohesion, and one's sense of self and citizenship, thus easing the transition and reintegration from institutionalism to independence. In my terminally optimistic moments, I feel confident that we stand on the brink of integrating our services effectively to ensure this happens.

The pieces are all there – care planning, ITEP, Common Assessment Frameworks, Think Family, Systems Change Pilot programmes, Every Child Matters, Every Parent Matters, Putting People First, joint guidance on development of local protocols between drug and alcohol treatment services and local safeguarding and family services, the ten-year drug strategy launched in 2008 – we just need a unified direction that has the vision, drive, confidence, commitment and ability to pull them all together and make them work. Let's do it.

Daren Garratt is executive director of the Alliance

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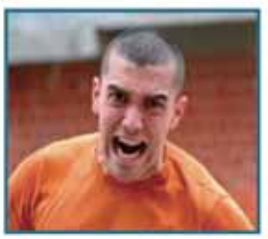

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Dates & Venues:

14 June 2010	Belfast	22 June 2010	Portsmouth
15 June 2010	London	23 June 2010	Glasgow
16 June 2010	Harrogate	24 June 2010	Newcastle
17 June 2010	Nottingham	25 June 2010	Manchester
18 June 2010	Birmingham	05 July 2010	London
21 June 2010	Bristol	21 September 2010	London

"Very enjoyable, Paul is an exceptionally talented speaker with extensive knowledge in his field" *D.E., Counsellor*

For further details on all SDS courses, in-house training & special offers and to BOOK ONLINE go to:

www.skillsdevelopment.co.uk OR call our friendly team on: 0870 241 7294

TRAINING DVDs FROM www.psychotherapydvds.com

Amber

transforming lives

Amber offers a safe residential environment for unemployed men and women aged 17– 30 who want the opportunity to make a new start.

Amber has a 15 year track record of getting people from socially excluded groups back into independent living, offering those who have lost their way the chance to put the past behind them and move forward.

A comprehensive package is available allowing the opportunity for a young person to progress from our rural centres in Devon and Surrey back into an urban environment.

What we offer:

- An alcohol and drug free environment with supervised testing, counseling services and relapse prevention
- Removal from negative peer groups and influences, allowing individuals to break from negative cycles
- The opportunity to learn skills and overcome barriers to progression, helping rebuild self-esteem and confidence
- In-depth needs assessment with an individually tailored action plan and regular progress reports
- Nationally accredited personal development courses, including basic skills and maintaining a tenancy
- Bed spaces available on a block contract or spot purchase basis
- Value for money

In addition to the above, for young people ready to move into further education or employment our Bythesea Lodge centre in Wiltshire also offers:

- An urban environment, close to amenities
- Projects with British Waterways on Amber's narrow boat
- Opportunities to return to further education and to enter employment, with on going support
- Accommodation whilst working towards self sufficiency

If you would like further details of what Amber has to offer or would like to visit one of the Amber centres, please contact Olly Giddings, Recruitment Manager on: 01769 582022 or email olly.giddings@amberweb.org

"Amber could be just the answer you are seeking. The benefits to the individual and society far outweigh the costs"

www.amberweb.org

Recovery Scotland 2010

Wednesday 23 June 2010
Edinburgh Corn Exchange

headline sponsor
TURNING POINT SCOTLAND

media partner
THE SCOTSMAN

Organisers
Pavilion
OLM

Alcohol and drug use and misuse is an immense and highly complex challenge for Scotland's health, social work, housing, criminal justice, and education professionals.

Recovery Scotland is a unique event taking a person-centred and community-led approach to alcohol and drug misuse.

Incorporating an **exhibition**, **seminar programme** and **zones**, Recovery Scotland is only **£20 to attend**.

To book your tickets and find out more visit
www.recovery-scotland.com
Email: **info@pavpub.com** Call: **0844 880 5061**

University of Kent
CONFERENCE CONSORTIUM

2nd Connections
European Conference: Drugs, Alcohol and Criminal Justice
Ethics, Effectiveness and Economics of Interventions

DRUGS, ALCOHOL AND CRIMINAL JUSTICE – ETHICS, EFFECTIVENESS AND ECONOMICS OF INTERVENTIONS

CENTRAL LONDON

23-25 JUNE 2010

The conference will look at a range of interventions and treatments, from harm reduction to drug-free recovery. The aim of the conference is to discuss and debate how the different components can be combined effectively, while demonstrating value for money.

Key issues

Service users in criminal justice: patients or prisoners?
How to create a system based on choice.
Is there a place for compulsory treatment?

Speakers include

Professor Ambros Uchtenhagen *– ethics of criminal justice interventions;* ***Professor Linda Davies*** *– cost-effectiveness of criminal justice interventions;* ***Professor Alex Stevens*** *– European good practice on criminal justice interventions*

Full details and booking at:

www.connectionsproject.eu

Professional Training for Drug & Alcohol Practitioners

Part-time courses from Autumn 2010

- Accredited, modular courses incorporating the "Models of Care" framework, DANOS competencies and QuADS benchmarks
- Recognised qualifications for all practitioners in areas including healthcare, criminal justice and social care
- Taught in five-day blocks
- Ideal for those new to or returning to study

Certificate in Substance Misuse Management (Stage 1)
This entry level Certificate is recognised as an accredited qualification that provides introductory training for all professionals working with problem substance users. The 18 month programme starts in September and runs in Canterbury and across the UK where there are cohorts of 10 or more.

Diploma in Substance Misuse Management (Stage 2)
The Diploma provides a framework for understanding the biological, psychological and social perspectives of problem substance use within the context of service provision. The programme aims to develop therapeutic understanding and client specific interventions against the backdrop of current research and thinking in the field. The 2 year programme starts in October and runs in Canterbury.

BSc in Substance Misuse Management (Stage 3)
This provides in-depth study of the psychological, environmental and biological aspects of addictive behaviours including ethics, research methods and a small research project. You will develop a detailed understanding of client assessment and outcome monitoring, skills required by project workers, managers and commissioners. The 2 year programme starts in November and runs in Canterbury.

Postgraduate research opportunities are also available.

For further information and to apply, please contact:
General Office
T: 01227 823072 E: socio-office@kent.ac.uk
www.kent.ac.uk/CHSS/

University of Kent

PCP
a new beginning

Drug and Alcohol Teams, Social Services

Look no further!

No waiting lists – immediate beds available

LUTON

- 24hours, 7 days a week care
- 24 beds quasi – residential primary care – £450 per week
- 12 week primary care and 12 week secondary care
- Detox facilitated
- 12 Step and holistic therapy
- EATA member
- Weekly reporting to NDTMS
- Block contracts available
- Client weekly reports

Chelmsford

- 24 hours, 7 days a week care
- 24 beds quasi – residential primary care - £495 per week
- 12 week primary care and 12 week secondary care
- Detox facilitated
- Luxury Accommodation
- 12 step and holistic therapy
- EATA member
- Weekly reporting to NDTMS
- Block contracts available
- Client weekly reports

CALL FREE 08000 380 480

Email: darren@pcpluton.com Web: www.rehabtoday.com

DDN/FDAP WORKSHOPS

DDN Drink and Drugs News

fdap

8 June

Dual diagnosis – training day

Using practical case studies and examples of good practice, Brendan Georgeson from Walsingham House will examine how to build and sustain a truly integrated service, how to overcome the fears of working with this client group and the transferable skills required. According to diagnostic criteria such as ICD10, dual diagnosis is defined as the co-occurrence of two or more disorders in an individual, where each disorder influences the course of the other. This training day will map various competence frameworks, including:

- *Mental Health National Occupational Standards - MHNOS 23: Plan and review effectiveness of therapeutic interventions with individuals with mental health needs, and MH14: Identify potential mental health needs and related issues.*
- *Drug and Alcohol National Occupational Standards - DANOS AF3: Carry out comprehensive substance misuse assessment, and DANOS AF2: Carry out assessment to identify and prioritise needs*
- *Knowledge and Skills Framework - KSF HWB7 Level 2: Interventions and Treatments, contribute to planning, delivering and monitoring interventions and/or treatments. It will also cover KSF HWB2 Level 3: Assessment and care planning to meet peoples' health and well-being needs*

15 June

Masterclass – registration with Care Quality Commission

All currently registered services will need to re-register with CQC between April and September 2010. Quasi-residential and community services will also need to register. David Finney, author of the national guidance for inspectors of residential services, will show you how to meet the new compliance criteria. *Cost: £135 + vat*

15 July

New psychoactives and other developments in drug use

This workshop will look at some of the latest developments in the use of psychoactive chemicals. It will cover information on mephedrone (4-mmc, miaow, m-cat), methylone, butylone, synthetic cannabinoids (Spice) and many others. Find out about tomorrow's drug use – today! The course is run by Ren Masetti, training co-ordinator for the Drug and Alcohol Action Team in Suffolk and freelance trainer. *Cost: £115 + vat*

15% discount to FDAP members. All courses run from 10am – 4pm in central London, and include lunch and refreshments. For more details about these workshops email ian@cjwellings.com or telephone 020 7463 2081.
Or visit: **www.drinkanddrugsnews.com**

SAdAS

SOUTHERN ADDICTIONS ADVISORY SERVICE

Due to internal promotions we are able to offer the following opportunity within SAdAS:

Manager

Guildford Office – 18 month contract

36 hours per week – salary range £25,600 - £27,520 (dependant on experience)

SAdAS is looking for a highly skilled individual with a proven track record for managing staff. The Engage Service is a fledgling but highly motivated team delivering Tier 2 Interventions across three Surrey boroughs. You will need to bring both expertise and real leadership. The post is offered on an initial 18 month contractual basis.

SAdAS rewards its staff for loyalty, hard work and dedication.

For a job description and application form contact Sue Murphy on 01483 590150 or email susan.murphy@sadas.org.uk.

The closing date is close of business Monday 17th May 2010.

SHEFFIELD DAAT

TENDER OPPORTUNITY

Sheffield DAAT, on behalf of the Safer Sustainable Communities Partnership, through NHS Sheffield, is reconfiguring the drug and alcohol treatment system over a two year period to ensure treatment is effective, recovery focused and provides value for public money. We are seeking expressions of interest from suitably qualified and experienced providers (including NHS, independent, social enterprise and third sector providers) to deliver the following services from January 2011:

- Tier 2 (Open Access, Assertive Outreach, Specialist Needle Exchange) and Other Structured Treatment (OST) (Drugs)
- Tier 2 Open Access & Assertive Outreach & The Single Entry & Assessment Point (SEAP) (Alcohol)
- Tier 3 Psychosocial Interventions (PSI) (Drugs & Alcohol)

This procurement will have TUPE implications.

A Bidder Information Event will be held on 11th May 2010, 9.00am -12.00pm.

To reserve a place at the information event or to express an interest and to request the documentation please go to www.sheffieldpct.nhs.uk/procurement where there is further information about the tender opportunity.

If you have any queries, contact the Healthcare Procurement team on 0114 305 1276 or email: daat.procurement@sheffieldpct.nhs.uk

The closing date for expressions of interest is midday on 27th May 2010.

POSITIVE ABOUT DISABLED PEOPLE

CDS SOUTH LONDON

COMMUNITY DRUG SERVICE for SOUTH LONDON

DAY PROGRAMME DRUGS WORKER

Part Time – 24 hours weekly
Grade 27, NJC Scale
(6% Employer's Contributory Pension Scheme)

The successful candidate mainly will provide the following: one to one support, group facilitation and life skills workshop within a day programme facility at CDSSL, Wallington, Surrey. Following our existing system and policies and national related guidelines and legislations.

For an Application Pack for this position, please call: 020 8773 9393

Closing date for completed applications: Monday 31st May

Registered charity No.1028663

Do you provide training in the field?

From universities to individual practitioners, the Winter 2009 Training and Development Directory featured over 160 training opportunities in the UK.

Did you miss out?

The Summer 2010 edition will appear as a pull out and keep section in the **24 May** *issue of DDN.*

To make this the most comprehensive training listing available, make sure you don't miss out on your free listing.

CALL FAYE NOW...

020 74632205 or faye@cjwellings.com

The DDN nutrition toolkit

"an essential aid for everyone working with substance misuse"

- **Written by nutrition expert Helen Sandwell**
- **Specific nutrition advice for substance users**
- **Practical information**
- **Complete with leaflets and handouts**

Healthy eating is a vital step towards recovery, this toolkit shows you how.

Available on CD Rom. Introductory price £19.95 + P&P

NEW – NOW AVAILABLE TO DOWNLOAD

To order your copy contact Charlotte Middleton: e: charlotte@cjwellings.com t: 020 7463 2085

BROADREACH HOUSE
DRUG AND ALCOHOL TREATMENT SERVICES
Supporting You in Rebuilding your Life

COUNSELLORS

Broadreach and Closereach

Salary: £18,000 – £23,340

(dependent upon qualifications and experience)

Broadreach House is an innovative and dynamic registered national charity, offering both residential and community-based drug and alcohol treatment support services.

We are looking for motivated, enthusiastic and experienced counsellors to join established teams at two of our drug and alcohol residential treatment centres (Broadreach and Closereach). Duties include delivering group therapy sessions, focus groups, carrying a client case load, one-to-one counselling, care planning and record management.

Counselling qualifications and experience are essential. Experience of working in the drug and alcohol field is desirable, though further training will be provided to those with limited experience of working with this client group.

Successful candidates will be required to apply for a CRB Enhanced Disclosure.

Closing date for applications: Noon on Wednesday 2nd June 2010. Interviews will take place on 10th and 11th June 2010.

Candidates shortlisted following interviews will be asked to participate in a one-day assessment centre, taking place on one of the following dates: 14th, 15th, 16th, 17th or 18th June.

For an application pack please email: hr@broadreach-house.org.uk or telephone our 24-hour voicemail facility on 01752 566212

Registered address: Unit Two, Ocean Quay, Richmond Walk Plymouth PL1 4LL

Broadreach House is an equal opportunities employer, and strongly encourages applications from all sections of the community.

bridge
a way forward

Bridge is a leading Bradfordbased charity with a long history of providing quality services in the drug treatment sector. We are looking to recruit enthusiastic and motivated individuals to fill the following posts:

Team Manager

Full Time 37.5hrs per week.
Salary £29,236 to £31/754 *(NJC Scale SCP 35 to 38) pay award pending*

You will lead a staff team to deliver to contract, including meeting key performance indicators, with quality at the heart of everything you do. This is an ideal opportunity for an experienced professional working in substance misuse with a good knowledge of substitute prescribing. Bridge is a growing organisation that prides itself on allowing staff and managers to grow and develop within their roles through our commitment to training and supervision.

Drug Worker (Young People's Drug and Alcohol Service)

Full time 37.5 hours per week
Salary: £23,708 to £26,276 *(NJC Scale SCP 28 to 31) pay award pending*

You will be in possession of either a relevant qualification (eg. Diploma in Youth and Community, Social Work, Counselling) ***or*** 2 years experience of working with people with drug/alcohol problems and/or working with young people/children with a commitment to work towards a relevant qualification. *Essential car user role*.

For more details please contact Beverley Bray on 01274 723863 or email beverley.bray@bradford.nhs.uk

Closing date: 5pm Wednesday 19th May 2010.
Interviews will be held on: Tuesday 1st and Wednesday 2nd June 2010.

www.bridge-bradford.org.uk

BOSENCE FARM COMMUNITY LTD

BOSWYNS

A NEW RESIDENTIAL DETOXIFICATION AND STABILISATION SERVICE

NURSES

£19,738 to £24,803

This is an unique and exciting opportunity to join and be involved in shaping a new service in a stunning building, in a beautiful West Cornwall setting, with a well established and respected charity.

We are recruiting Nurses (both RGN's and RMN's)

You will be delivering assessment, detoxification and stabilisation services with short term psycho-social interventions within a multi-disciplinary team on a shift rota providing 24 hour staffing.

Some experience of drug/alcohol treatment and of delivering residential detoxification and stabilisation will be an advantage.

Combine an exciting challenge with a Cornish lifestyle!

For an application pack email charmaine@bosencefarm.com or telephone the administration team on 01736 850006, or download from www.bosencefarm.com

Closing Date – 28th May 2010
Interviews W/C – 7th June 2010

Compass

Compass is a rapidly expanding independent sector organisation providing services to help communities cope with problem drug and alcohol use. Due to the expansion of our services in Yorkshire, we now have the following exciting opportunities available:

Hull Services

Harm Reduction Worker 37 hours per week | £20,454 - £24,201 p.a. | Ref: 173
Young People's Drug and Alcohol Worker
37 hours per week £20,454 - £24,201 p.a. | Ref: 174
Nurse Senior Practitioner 37 hours per week | £27,212 - £29,314 p.a. | Ref: 175
Practice Nurse 37 hours per week | £21,115 - £26,470 p.a. Ref: 176

Sheffield Service

Service Manager 37 hours per week | £31,162 - £36,683 p.a. | Ref: 170
Case Manager / Trainer x4 37 hours per week | £20,454 - £24,201 p.a. | Ref: 171
Administrator 37 hours per week | £12,869 - £15,625 p.a. | Ref: 172

York Services

Criminal Justice Worker 22 hours per week | £20,454 - £24,201 pro rata p.a. | Ref: 178

We believe that a healthy work/life balance is key to a successful and rewarding career so we are proud to be able to offer:

- 27 days annual leave per year + 8 Bank Holidays
- Free Employee Assistance Programme
- Compass Group Personal Pension Scheme
- Childcare Voucher Scheme
- Excellent Training Opportunities

For more information and details of how to apply, visit www.compass-uk.org

Please see our website for closing dates of individual posts.

All Compass posts are subject to an Enhanced CRB disclosure.

www.Compass-uk.org

Charity registration No: 518048